

Prostate Cancer PET/CT Imaging Request



For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. **URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.**

Patient/Member	First Name:		Middle Initial:	Last Name:		
	DOB (mm/dd/yyyy):			Gender:	Male	Female
	Street Address:				Apt #:	
	City:			State:	Zip:	
	Home Phone:		Cell Phone:		Primary Contact:	Home Cell
	Health Plan:		Member ID:		Group ID:	
	Ordering Provider	First Name:			Last Name:	
Primary Specialty:		TIN:	NPI:			
Physician Phone:			Physician Fax:			
Address:				Suite #:		
City:			State:	Zip:		
Office Contact:					Ext:	
Contact Email:						
Facility/Site	First Name:			Last Name:		
	Group/Site Name:					
	Primary Specialty:		TIN:	NPI:		
	Site Phone:			Site Fax:		
	Address:				Suite #:	
	City:			State:	Zip:	
Procedure	This form is for PET or PET/CT requests only. Diagnostic CT scans should be requested separately.					
	Check all applicable CPT Codes:	78811	78812	78813	78814	
		78815	78816	Other:		
Diagnosis	Diagnosis, if known or rule out:					
	ICD-10 Codes:					
	Date of last visit:					

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Clinical Information

1. Does the requested imaging meet a requirement for a clinical trial protocol?

NCI sponsored clinical trials (Clinical Trial Number):

Industry sponsored clinical trial

Does not qualify for a clinical trial protocol

Don't Know

2. Has cancer diagnosis been confirmed by biopsy?	Yes	No	Don't Know
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3. Is this for hormone refractory disease?	Yes	No	Don't Know
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4. Is PSA increasing on two consecutive measurements? (PSA: Prostate Specific Antigen lab test)	Yes	No	Don't Know
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5. Has a bone scan been done?	Yes	No	Don't Know
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Additional Information/Comments:

Submitter

Who is making this request? Ordering Physician Facility Other:

Print Name:

Title: MD RN LPN PA NP Other:

Signature:

Date: