PET/PET CT Scan Clinical Certification Request Form

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:

Diagnosis

Diagnosis, if known or rule out:
ICD-10 Codes:
Date of last visit:

Procedure

Check all requested CPT Codes or G Codes:

- ☐ 78811 PET, limited
- ☐ 78812 PET, skull base to mid thigh
- ☐ 78813 PET, whole body
- ☐ 78608 Brain imaging, PET metabolic evaluation
- ☐ 78609 Brain imaging, PET perfusion evaluation
- ☐ 78814 PET with CT, limited
- ☐ 78815 PET with CT, skull base to mid thigh
- ☐ 78816 PET with CT, whole body
- ☐ 78459 Myocardial imaging, PET, metabolic
- ☐ 78491 Myocardial imaging, PET, single study
- ☐ 78492 Myocardial imaging, PET, multiple studies
- ☐ G0219 PET, whole body for melanoma
- ☐ G0252 PET, breast cancer
- ☐ G0235 PET, unlisted

Clinical Information

Cell type or tissue diagnosis and date of diagnosis:	Stage:

Reason for study: ◯ Initial Staging ◯ Restaging ◯ Suspected Recurrence ◯ Surveillance ◯ Evaluation for biopsy site

Other rationale for this examination:

Prior imaging results (include type of examination and dates):

Current tumor markers and date:

Most recent past tumor markers and date:

If applicable:	Is nodule, mass or lesion 7mm or larger?
	What is the size?

Liver function tests:	Alkaline phosphatase

Current symptoms:

Current findings on physical examination:

Clinical Information

Currently on chemotherapy?	◯ Yes	◯ No	
Completed chemotherapy?	◯ Yes	◯ No	Date:
Currently on radiotherapy?	◯ Yes	◯ No	
Completed radiotherapy?	◯ Yes	◯ No	Date:
Surgery?	◯ Yes	◯ No	Date:

If yes, please explain.

Known metastic disease: ◯ Yes ◯ No

If yes, please check all that apply:

☐ Liver	☐ Kidney	☐ Brain
☐ Pancreas	☐ Bone	☐ Spine
☐ Lung	☐ Bowel	☐ Ovary
☐ Spleen		

Lymph nodes involved:

☐ Cervical	☐ Retroperitoneal	☐ Hilar
☐ Celiac	☐ Supraclavicluar	☐ Iliac
☐ Axillary	☐ Porta Hepatis	☐ Pelvic
☐ Mediastinal	☐ Inguinal	☐ Other:

How will the results of this test influence patient management?

Other pertinent information:

Submitter

Who is making this request? ◯ Ordering Physician ◯ Facility ◯ Other:

Print Name:

Title: ◯ MD ◯ RN ◯ LPN ◯ PA ◯ NP ◯ Other:

Signature: Date: