



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:					

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Procedure	Check all requested CPT Codes or G Codes:	78811 PET, limited	78816 PET with CT, whole body
		78812 PET, skull base to mid thigh	78459 Myocardial imaging, PET, metabolic
		78813 PET, whole body	78491 Myocardial imaging, PET, single study
		78608 Brain imaging, PET metabolic evaluation	78492 Myocardial imaging, PET, multiple studies
		78609 Brain imaging, PET perfusion evaluation	G0219 PET, whole body for melanoma
		78814 PET with CT, limited	G0252 PET, breast cancer
		78815 PET with CT, skull base to mid thigh	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 metastatic 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	Supraclavicular	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:			