



PET SCAN
Precertification Request Form
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Fax: 800-540-2406

PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED COMPLETELY. FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST.

Patient Name _____ DOB _____

Insurance Plan _____ Subscriber ID _____

Referring Physician _____ Physician ID _____

Physician Address _____ City _____ State _____

Physician Fax #(____) _____ Phone #(____) _____

Date of Request _____ Contact Person _____

Imaging Facility Name _____ Site Phone #(____) _____

Site Address _____ City _____ State _____

Please circle the CPT or G code you are requesting:

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

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 _____

Liver function tests _____ Alkaline Phosphatase _____

Current symptoms _____

Current findings on physical examination _____

Patient ID _____
Health Plan _____

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Currently on Chemotherapy Yes _____ No _____

Completed Chemotherapy Yes _____ No _____ Date _____

Current 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 ___ Lung ___ Bone ___ Brain ___ Ovary ___ Spleen ___ Pancreas ___ Kidney ___ Bowel ___ Spine ___

Lymph nodes involved:

Cervical ___ Axillary ___ Supraclavicular ___ Hilar ___ Mediastinal ___ Retroperitoneal ___

Celiac ___ Pelvic ___ Porta Hepatis ___ Iliac ___ Inguinal ___ Other ___

How will the results of this test influence patient management? _____

Other Pertinent Information _____

Signature of Requesting Physician

Date