



400 Buckwalter Place Blvd  
Bluffton, SC 29910

# PET SCAN PRECERTIFICATION FAX FORM

Phone: 1 (888) 333-9036  
Fax: 1 (888) 785-2487

Date: \_\_\_\_\_

From: \_\_\_\_\_  
(Physician or Practice Name)

Patient's Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_  
(Street, City, State, Zip)

Patient's Contract Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

### Please check the box/boxes this fax pertains to:

- Initiating a New Precertification Request
- Providing Written Clinical Certification Notes
- Providing **Additional** Clinical Information (for Review in Progress)
- Appeal \_\_\_\_\_
- Other \_\_\_\_\_

The following information will assist CareCore in completing your request more efficiently:

- Relevant Medical Records and/or Results of Prior Imaging
- Clinical Office and/or Consultation Notes
- Signed and Dated Clinical Summary Documenting Indications for This Examination(s)

**Fax completed PET Scan Precertification Fax Form to CareCore National, LLC at (888) 785-2487.**  
You may retain a blank copy of the request form for future use.

Number of Pages: \_\_\_\_\_

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# PET SCAN

## Precertification Request Form

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

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Address \_\_\_\_\_

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
		S8085	Fluorine-18 Fluorodeoxyglucose dual head

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 Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

**PET SCAN**  
**Precertification Request Form**  
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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