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: _____

PET SCAN
Precertification Request Form

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

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 ☐ Supraclavicluar ☐ 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