PET – PET CT PRIOR AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS						
Patient Name (First, Last):		В:				
Health Plan:	Member ID #: Grou			oup #:		
SECTION 2. ORDERING PROVIDER INFORMATION						
Physician Name (First, Last):						
Primary Specialty:	NPI:		Tax ID:			
Phone #:	Fax #:		Contact Name:			
SECTION 3. FACILITY INFORMATION						
Facility Name:		Facility Tax ID:		NPI:		
Address:	City:		State:		Zip:	
Phone #:	Fax #:			Date of	Service:	
SECTION 4. EXAM REQUEST						
CPT Code(s):						
Description:						
ICD Diagnosis Code(s):						
Description:						
Date of first office visit for this condition with any provider:						
Date of most recent office visit for this condition with any provider:						
SECTION 5. COMPLETE ALL APPLICABLE INFORMATION AND CHECK THE ALL BOXES THAT APPLY						
Tumor Type : Date of Diagnosis:						
Select Radiotracer that applies:						
Standard or Routine PET or PET/CT Imaging FDG (2 fluorine 18, fluoro 2 deoxy-d-glucose)						
PET Bone Scan: Sodium 18F Fluoride PET/CT						
Other (describe):						
Does patient have a cancer diagnosis confirmed by biopsy? 🗌 Yes 🗌 No						
Patients Treatment History:		Reason for study:				
□ No treatment for this type of cancer (initial staging)		Initial staging				
□ Treatment with surgery alone for this type of cancer		Restaging, surveillance				
Treatment other than surgery alone for this cancer		□ Interim PET/CT for response-adapted therapy				
Currently on chemotherapy: 🗌 Yes 🔲 No	Currently on radiotherapy: 🗌 Yes 🔲 No					
Completed chemotherapy: 🗌 Yes 🗌 No		Completed radiotherapy: 🗌 Yes 🔲 No				
Date completed: Date completed:						
Does patient have known cancer spread to other parts of the body beyond primary tumor (metastatic disease)?: 🗌 Yes 🗌 No						
Is there suspicion of recurrence or progression based on signs, symptoms, or imaging findings?: 🗌 Yes 🗌 No						
Prior Imaging Results and Dates:						
Additional Information:						

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.