



Utilization Management
Phone No.: 1-877-284-0102 Fax No.: 1-800-510-2162

PET Scan Pre-Review

Date: _____ Notification # _____ (provided after initial review)
A Utilization Management representative will fax you a notification number by the next business day after receiving this completed form. This notification number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care department. If you have any questions, please call Healthlink at 1-877-284-0102.

Provider Information

Provider/Facility Name _____
Address _____
Phone No. _____ Fax No.(Required) _____

Patient Information

Patient's Name: _____ Patient's DOB: _____
ID Number _____ Daytime Phone No. _____
Address _____

Ordering Physician Information

Physician's Name: _____
Address _____
Phone No. _____ Fax No. _____
TIN: _____ Doctor's script on file YES NO

Clinical Information:

Diagnosis: _____
CPT code or codes requested: _____

Neurologic Pet Scan:

Does this patient have intractable epilepsy? YES NO
Is this for identification or localization of seizure foci, Please explain: _____

Is this patient a surgical candidate? YES NO

Cardiac:

Is this to assess myocardial viability in a patient with severe left ventricular dysfunction YES NO

Is this patient a candidate for surgery? If so, what type of surgery _____

Is this test being used to determine the presence of coronary artery disease YES NO
Was a SPECT scan unavailable? YES NO
Was a SPECT scan inconclusive? YES NO

Does that patient have a body habitus or other condition which would or could cause a SPECT Attenuation problem and/or other technical problem? If so, please explain? _____

Does the patient have a condition for which angiography would pose a high risk morbidity? _____

Oncology:

What type of primary cancer does this patient have? _____

Is this for surveillance purposes of known cancer or tumor? YES NO
Is this for initial staging? YES NO
Is this for restaging? YES NO

When was the patient's last chemotherapy and/or radiation treatment? _____

If the cancer has been treated surgically, when was the date of surgery? _____

What therapies are planned for this patient following the PET scan? _____

Has an MRI, CT scan or ultrasound been planned or has it already been performed? Please explain any results you may have for the preceding tests and when they occurred. If the test is being planned, when do you anticipate performing the test? _____

Any additional information we should know regarding why this PET scan is being performed? _____

Contact Information

Contact Person _____
Phone No. _____ Fax No. _____

Staff Signature/Title: _____ Date: _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment