



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

PET Scan Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference 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: _____
 Fax: _____

Patient Information

Patient Name: _____
 Patient DOB: _____
 ID Number: _____
 Address: _____
 Phone: _____

Ordering Physician Information

Physician Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Is the doctor script on file? YES NO

Treatment 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? YES NO

If yes, please explain: _____

Is this for an evaluation of dementia? YES NO

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

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

Is this patient a candidate for surgery? YES NO

If yes, 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? YES NO

If yes, please explain? _____

Does the patient have a condition for which angiography would pose a high risk morbidity? YES NO

Oncology

What type of primary cancer does this patient have? _____

Are there metastatic sites? YES NO

If yes, what are the sites? _____

Is the scan for initial therapy (initial staging)? YES NO

Are imaging results required to determine one of the following?

If the individual is a candidate for an invasive diagnostic or therapeutic procedure of an internal body structure

The appropriate anatomic location for an invasive procedure

The extent of malignancy when recommended therapy reasonably depends upon the extent of malignancy

More standard imaging modalities, (e.g., CT, MRI, or ultrasound) are either not indicated or unable to conclusively provide the required information

Is the scan for restaging or monitoring? YES NO

If yes, please answer the following:

Has the patient completed initial therapy for malignancy?

Are imaging results required to assess therapeutic success, in order to establish the need for, or scope of, any subsequent therapy?

Are scans to determine any of the following?

Presence or extent of residual disease

Presence or extent of recurrent disease

Presence or extent of metastasis

Other assessment of tumor response

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

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

Was the cancer treated surgically? YES NO

If yes, 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? _____

Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____