PET/CT Request Form

To Schedule PET Scans:
Please FAX this form to 708.226.2509, then
Contact the PET Scheduler at 708.226.2500

Palos Imaging & Diagnostics

Patient Information

Patient Name: _____ **Primary Insurance:** _____

Date of Birth: _____ **Age:** ____ **Sex:**____ **Secondary Insurance:** _____

Patient Home Phone #: _____ **Cell Phone#:** _____

Please note: Predetermination of benefits will be performed prior to services rendered. Some health insurance plans require Prior Authorization (pre-certification) for PET/CT scans in order to determine if the service requested meets criteria for medical necessity. Prior Authorization is dependent on clinical information provided by your office.

~ COMPLETION OF THIS FORM IN FULL WILL EXPEDITE SCHEDULING ~

Reason for PET/CT Exam

Primary Diagnosis: (site specific): _____ ICD-10 Code: _____

- ☐ Standard Body (78815 Skull Base to Mid-thigh)
  - ☐ Initial Treatment Strategy (PI)
  - ☐ Subsequent Treatment Strategy (PS)
- ☐ Prostate Axumin F18
- ☐ Neuroendocrine (NETSPOT) Gallium GA-68 Dotatate
- ☐ Whole Body (78816 Melanoma, Myeloma, or Below Knee)
  - ☐ Initial Treatment Strategy (PI)
  - ☐ Subsequent Treatment Strategy (PS)
- ☐ Brain (78608 Metabolic Eval; Seizures; Dementia)
  - ☐ Initial Treatment Strategy (PI)
  - ☐ Subsequent Treatment Strategy (PS)

Prior Imaging History

Has patient had prior imaging related to this condition? ☐ Yes ☐ No

If so, please indicate type (CT, MRI, PET), when & facility name: _____

_____

Provider Information

Provider Name: _____ Office Contact (RN/MA): _____

Provider Phone#: _____ Provider FAX#: _____

Provider Signature: _____ Date: _____

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SCRIPTS