



**BlueCross BlueShield
of Alabama**



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An Independent Licensee of the Blue Cross and Blue Shield Association.

PET SCAN PRECERTIFICATION FAX FORM

For precertification status, sign in to ProviderAccess via www.bcbsal.com.

Date: _____

From: _____
(Physician or Practice Name)

Patient's Name: _____

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)

You may retain a blank copy of the request form for future use.

Number of Pages: _____

CONFIDENTIALITY NOTICE: The attached information to this facsimile transmission is **CONFIDENTIAL** and is intended only for the use of the recipient(s) identified above. It may contain confidential and protected health information subject to privacy regulations such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you are not the intended recipient or a person responsible for delivering it to the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of any of the information contained in or attached to this transmission is **STRICTLY PROHIBITED**. If you have received this transmission in error, please notify me immediately by telephone and destroy the transmission and its attachments without saving them in any manner.

Patient Name: _____ Patient's Contract #: _____

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PLEASE BE ADVISED THAT ALL QUESTIONS MUST BE ANSWERED COMPLETELY. FAILURE TO DO SO MAY DELAY THE DETERMINATION OF YOUR REQUEST. IF NOT APPLICABLE, USE N/A.

Patient Name _____ DOB _____

Insurance Plan Blue Cross and Blue Shield of Alabama Patient's Contract # _____

Referring Physician _____ Provider # _____

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

*** Supporting clinical notes must be faxed to initiate the precertification process.**

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 _____

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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 Supraclavicular 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