



**BlueCross BlueShield  
of Alabama**



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

169 Myers Corners Road  
Wappingers Falls, NY 12590  
Telephone: 866 803-8002  
Fax: 866 466-6964

## PET SCAN PRECERTIFICATION FAX FORM

For precertification status, sign in to ProviderAccess via [www.bcbsal.com](http://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:** \_\_\_\_\_

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Patient Name: \_\_\_\_\_ Patient's Contract #: \_\_\_\_\_

## PET SCAN Precertification Request Form

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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 NPI \_\_\_\_\_

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 \_\_\_\_\_

**To check precertification status check ProviderAccess via [www.bcbsal.com](http://www.bcbsal.com).**

Patient Name: \_\_\_\_\_ Patient's Contract #: \_\_\_\_\_

**PET SCAN**  
**Precertification Request Form**  
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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