



PET PRECERTIFICATION REQUEST FORM

Please complete the requested information and return to CareCore National, LLC (CCN) by faxing to the following:

Fax: 866-466-6964
Telephone: 866-803-8002

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.

CareCore National is an independent specialty benefit management company that manages precertification services on behalf of Blue Cross and Blue Shield of Alabama.

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Patient Name _____
Contract # _____
Blue Cross and Blue Shield of Alabama

PET SCAN Precertification Request Form

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 _____ Zip _____

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	78491	Myocardial imaging, PET, single study
78812	PET, skull base to mid thigh	78492	Myocardial imaging, PET, multiple studies
78813	PET, whole body	78608	Brain imaging, PET metabolic evaluation
78814	PET with CT, limited	78609	Brain imaging, PET perfusion evaluation
78815	PET with CT, skull base to mid thigh	G0219	PET, whole body for melanoma
78816	PET with CT, whole body	G0252	PET, breast cancer
78459	Myocardial imaging, PET, metabolic	G0235	PET, Unlisted

CPT codes, descriptions, and other data only are copyright © 2010 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

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