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NUCLEAR MEDICINE AUTHORIZATION REQUEST FORM

1 PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____
 DOB: ____ / ____ / ____ Gender (Circle): M F
 Insurance Company Name: _____
 Policy ID #: _____

2 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____
 Fax #: _____
 INS Provider / Tax ID#: _____

Diagnosis 1: _____ ICD10 Code 1: _____

Diagnosis 2: _____ ICD10 Code 2: _____

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): (MANDATORY)

Findings from prior radiology exams: _____

3 AUTHORIZATION REQUEST FOR RADIOLOGY (MANDATORY)

PET/CT

- Brain
- Cardiac
- Oncology (Skull - Mid Thigh)
Type of Cancer: _____
- Melanoma (whole body)
- Other: _____
CPT Code: _____

Isotope agent:

- FDG
- NaF

NUCLEAR MEDICINE

- Biliary Ejection Fraction
- Biliary Scan
- Bone Scan 3 Phase
- Bone Scan Limited
- Bone Scan Total
- Gallium Scan
- Gastric Emptying Scan
 Liquid Solid
- Hepatobiliary Scan
- Hepatobiliary Scan with Ejection Fraction
- Liver/Spleen Scan
- Gated (MUGA/Cardiac Blood Pool)
- Parathyroid Scan
- Other: _____
CPT Code: _____

- Renal Pharmacological Intervention
 Lasix Captopril
- Salivary Gland Function
- Thyroid Uptake and Scan
- SPECT Bone
- SPECT Brain
- SPECT Liver
- SPECT Liver for Hemangioma
- SPECT Tumor Localization

Please notify me _____ days before authorization expiration.

Submitted by: _____ Phone #: _____ Date: ____ / ____ / ____

4 Fax completed forms to: 855-677-9783