



72 West Jimmie Leeds Road, Suite 1100  
 Galloway, New Jersey 08205  
 Phone: 855-677-9729  
 Fax: 855-677-9783

**NUCLEAR MEDICINE AUTHORIZATION REQUEST FORM**

**1 PATIENT INFORMATION (PLEASE INCLUDE PATIENT DEMO SHEET, IF AVAILABLE)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender (Circle): M F  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
 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**