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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