IMAGING ASSOCIATES
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TEL 907.222.4624
FAX 907.222.4651
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PHYSICIAN REQUEST FOR PET IMAGING

DATE OF REFERRAL	REFERRING PHYSICIAN
SIGNATURE OF REFERRING PHYSICIAN (REQUIRED FOR EXAM)	

PATIENT INFORMATION

LAST NAME	FIRST	M.I.	DATE OF BIRTH

SSN#	MOBILE PHONE	HOME PHONE

ADDRESS	CITY	STATE	ZIP

INSURANCE: PRIMARY	SECONDARY

HEIGHT	WEIGHT	DIABETIC ☐ Y ☐ N

CLINICAL REASON

☐ INITIAL STAGING/INITIAL TREATMENT STRATEGY ☐ RESTAGING/SUBSEQUENT TREATMENT STRATEGY ☐ DIAGNOSIS

☐ STANDARD PET/CT (SKULL BASE TO MID THIGH) 78815 ☐ WHOLE BODY PET/CT (SKULL TO FEET/I.E. MELANOMA) 78816

☐ PET/CT BRAIN 78814 ☐ PET/CT PSMA (PROSTATE) ☐ PET/CT DOTATATE (KNOWN NEUROENDOCRINE TUMOR)

CLINICAL INFORMATION

DIAGNOSIS/REASON FOR EXAM

ICD-9 CODE(S)

MEDICARE AND OTHER INSURERS REQUIRE CODING OF SPECIFIC/DEFINITIVE DIAGNOSIS(ES), SIGN(S) OR SYMPTOMS(S) TO REFLECT THE "MEDICAL NECESSITY" FOR EACH TEST. RULE OUT, POSSIBLE, OR PROBABLE CONDITIONS CANNOT BE CODED. FOR MEDICARE POLICY INFORMATION SEE THE PART B BULLETIN OR NORIDIAN.COM/MEDWEB.

REQUIRED DOCUMENTATION

INSURANCE COVERAGE FOR PET SCANS IS LIMITED AND MUST BE PRE-AUTHORIZED BY THE PATIENT'S INSURANCE CARRIER. THIS PROCESS WILL BE COORDINATED BY IMAGING ASSOCIATES. PLEASE ASSIST US BY FAXING THIS FORM AND THE FOLLOWING ITEMS TO 907.222.4651.

☐ COPY OF INSURANCE CARDS (BOTH SIDES)

☐ BIOPSY REPORT AND H&P OR CHART NOTES SUPPORTING MEDICAL NECESSITY

☐ REPORTS FROM PREVIOUS PET, CT, MRI, NUCLEAR MEDICINE, PATHOLOGY, ULTRASOUND, X-RAY, ETC., SUPPORTING PRIMARY DIAGNOSIS AND MEDICAL NECESSITY.

☐ PET/CT PSMA - LAST 2 PSA LABS (REQUIRED)

☐ PET/CT DOTATATE - SOMATOSTATIN USE? ☐ Y ☐ N

NAME: _____ LAST DOSE DATE: _____

AMERICAN COLLEGE OF RADIOLOGY ACR AMERICAN COLLEGE OF RADIOLOGY BREAST IMAGING CENTER OF EXCELLENCE