CMO
MONTEFIORE CARE MANAGEMENT

# PET SCAN CLINICAL CERTIFICATION FORM

**Date of Request:** ______________________

**Patient Name:**
**Patient Address:**
**City:** **State:**
**Patient Phone #:**
**Insurance Plan:**
**Member ID #:** **DOB:**

**Requesting Physician:**
**Physician Address:**
**City:** **State:**
**Physician's Phone #:**
**Physician's Fax #:**
**Contact Name:** **Contact Phone:**

**Is the condition a result of a motor vehicle accident?** ☐ **Yes** ☐ **No**

**Is the condition a result of work-related incident?** ☐ **Yes** ☐ **No**

**Imaging Facility Name:**
**Imaging Facility Tax ID:**
**Address:**
**City:** **State:**
**Contact Phone #:**
**Contact Fax #:**

**Requested CPT/Exam:**

**ICD-9:**

**Medicare Covered Diagnosis (Check one):**

- ☐ New solitary nodule on CXR
- ☐ Lymphoma/Hodgkin's Disease
- ☐ Melanoma
- ☐ Non small cell carcinoma of the lung
- ☐ Colon cancer
- ☐ Esophageal cancer
- ☐ Breast cancer
- ☐ Head/neck cancer
- ☐ Suspected recurrent thyroid cancer

(Provide full details under additional info.)

- ☐ Cervical cancer
- ☐ Ovarian cancer
- ☐ Other Solid Tumor

**Purpose of Scan (Check those that apply):**

- ☐ Baseline scan as part of staging

(Include suspicious of spread under additional info)

- ☐ Baseline scan positive and:
- ☐ Periodic assessment during chemotherapy/radiation
- ☐ Restaging after chemotherapy/radiation completed
- ☐ Periodic assessment during remission w/o new sx/findings

**Prior tests, treatments and interventions (Include duration if applicable):**

- ☐ CT/MRI nondiagnostic (Under addl info: include nondiag for what)
- ☐ Suspected recurrence/metastases (Include full details under addl info)

**On Active Treatment:** ☐ **Yes** ☐ **No**
**Date of last intervention:**
**Chemotherapy:** **Radiation:**

**Other Diagnosis:** ______________________________________________

**New symptoms/findings (Check those that apply):**

- ☐ Night sweats by hx
- ☐ Weight loss by hx/PE
- ☐ New/enlarged by Lymph nodes (provide detail under addl info)
- ☐ New lesion(s) – (provide detail under addl info)
- ☐ ESR > 30 mm/hr
- ☐ Temp > 100.4 F > + 1 wk unknown etiology
- ☐ CEA increasing/elevated
- ☐ Other new symptoms/findings (specify under addl info)

**How will this test alter the patient's management?**

**Additional Information:**

**Required Physician's Signature:** **Date:**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY, AS FAILURE TO DO SO MAY DELAY THE DECISION.**

**PAYMENT OF CLAIMS ASSOCIATED WITH THIS REFERRAL IS SUBJECT TO ALL CONTRACT TERMS, BENEFIT LIMITATIONS AND EXCLUSIONS, INCLUDING ELIGIBILITY FOR BENEFITS ON THE DATE OF SERVICE.**

**Radiology Line (866) 666-8388 Radiology Fax Line (914) 457-9509**

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