Na F18 Bone PET Scan - Scheduling Request

The Regional Cancer Center
In affiliation with UPMC CancerCenter

Check In Time:_____
Date of Service:_____
Please FAX form to: (814) 836-2648
Phone: (814) 836-2642

Today's Date: _____
Patient Name: _____
Address: _____
_____
Email Address: _____
☐ Unknown at this time ☐ None Declined
RCC #: _____
Social Security #: _____
DOB: _____
Phone: _____

Procedure:

Whole Body PET Bone Scan (head through toes – CT for attenuation correction only)

Primary ICD-9 code must be 733.90 with either secondary code 198.5 or 199.1

Diagnosis:_____ **ICD-9 Code:**_____
ICD-10 Code:_____
Scheduling Comments:_____ **CPT Code:** Please obtain authorization for 78816 **&** A9580

Reason for PET Bone (please check one):

- ☐ **Diagnosis** of suspected osseous metastatic disease ***in a patient without a pathologically proven diagnosis of cancer***
- ☐ **Initial staging** of newly diagnosed cancer
- ☐ **Suspected *new* osseous metastasis** as a site of recurrence or progression
- ☐ **Suspected progression of known osseous metastasis**
- ☐ **Monitoring Treatment Response**

Symptoms, Signs, or Other Findings Prompting F-18 Fluoride PET Bone Imaging *(Check all that apply)*

- ☐ Other:_____
- ☐ Skeletal pain
- ☐ New focal neurologic signs or symptoms
- ☐ Findings on other imaging studies suggesting osseous metastatic disease
- ☐ Hypercalcemia
- ☐ Elevated or increasing tumor marker(s) (including alkaline phophatase)
- ☐ Evidence of new metastases in non-osseous sites
- ☐ Evidence of progression of known metastatic disease in non-osseous sites

Cancer Type – check the one pathologically proven or strongly suspected cancer type that most closely relates to the specific reason for the PET study indicated in response to Question 1. *(Check only one)*:

- ☐ Lung
- ☐ Female Breast
- ☐ Prostate
- ☐ Metastatic cancer of unknown primary origin
- ☐ Other:_____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____
ID #: _____ **ID #:** _____
Group#: _____ **Group #:** _____
Rep Name: _____

Authorization #: _____ **Exp.:** _____
If no auth required, name of person spoken to: _____

FAX all of the following information with scheduling request:
❒Most recent imaging report ❒Pathology report ❒Tumor Marker Labs
❒Physician progress note (need only if proving medical necessity)

MD Name (print): _____ **MD Signature:** _____
Office Phone: _____ **Office Contact:** _____