SOUTH JERSEY RADIOLOGY ASSOCIATES (Please ATTACH Prescription)

NUCLEAR MEDICINE AUTHORIZATION REQUEST FORM

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

DOB: _____ / _____ / _____ Gender (Circle): M F Patient Phone Number _____

Insurance Company Name: _____

Policy ID# _____

☐ COPY OF INSURANCE CARD REQUIRED (front & back) ☐ COPY OF PRESECRIPTION / ELECTRONIC ORDER REQUIRED

PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____

City: _____ Zip: _____ __

Fax #: _____ __

NPI # / Tax ID#: _____

REFERRED TO

Name: SOUTH JERSEY RADIOLOGY

State: **New Jersey** Zip:_____

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: _____

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

Submitted by: _____ Phone: _____ Date: _____ /_____ /_____

FAX completed forms to: (856) 772-0268

Rev 06/01/18 td