RADCON NUCLEAR MEDICINE AUTHORIZATION REQUEST FORM

1 CHOOSE A SITE LOCATION

☐ Atlantic Medical Imaging ☐ Booth Radiology ☐ Larchmont Medical Imaging ☐ Princeton Radiology Excellence in Imaging ☐ SJRA South Jersey Radiology Associates, P.A.

2 PATIENT INFORMATION

Patient First Name:_____ Patient Last Name: _____

DOB: _____ / _____ / _____ Gender (Circle): **M** **F**

Insurance Company Name: _____

Policy ID #_____

3 PROVIDER INFORMATION

ATTENDING PHYSICIAN

Name: _____

Fax #: _____

INS Provider / Tax ID#:_____

REFERRED TO

Name: _____

City:_____

State:_____ Zip: _____

Diagnosis 1: _____ ICD9 Code 1:_____

Diagnosis 2:_____ ICD9 Code 2: _____

Clinical History (Please include lab results, radiology results, prior treatment, symptoms, including duration): **(MANDATORY)**

_____

_____

Findings from prior radiology exams: _____

4 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: _____ / _____ / _____

5

Fax completed forms to: (855) RADCON2 (723-2662)

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Moorestown, New Jersey 08057
Phone: (855) RADCON1 (723-2661)