

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-10 CODE(S)	MEDICARE AND OTHER INSURERS REQUIRE CODING OF SPECIFIC/DEFINITIVE DIAGNOSIS(ES), SIGN(S), OR SYMPTOM(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: _____

REV 03/2026