United HealthCare Services, Inc. – Please attach completed form to www.UHCProvider.com/paan secure online request or fax to **1-855-352-1206.** You may also call the toll-free number on your health plan ID card.

CLEAR FORM

PET – PET CT PRIOR AUTHORIZATION FORM

SECTION 1. MEMBER DEMOGRAPHICS		
Patient Name (First, Last):		DOB:
Health Plan:	Member ID #:	Group #:

SECTION 2. ORDERING PROVIDER INFORMATION		
Physician Name (First, Last):		
Primary Specialty:	NPI:	Tax ID:
Phone #:	Fax #:	Contact Name:

SECTION 3. FACILITY INFORMATION			
Facility Name:	Facility Tax ID:		NPI:
Address:	City:	State:	Zip:
Phone #:	Fax #:		Date of Service:

SECTION 4. EXAM REQUEST
CPT Code(s):
Description:
ICD Diagnosis Code(s):
Description:
Date of first office visit for this condition with any provider:
Date of most recent office visit for this condition with any provider:

SECTION 5. COMPLETE ALL APPLICABLE INFORMATION AND CHECK THE ALL BOXES THAT APPLY	
Tumor Type :	Date of Diagnosis:
Select Radiotracer that applies: ☐ Standard or Routine PET or PET/CT Imaging FDG (2 fluorine 18, fluoro 2 deoxy-d-glucose) ☐ PET Bone Scan: Sodium 18F Fluoride PET/CT ☐ Other (describe): _____	
Does patient have a cancer diagnosis confirmed by biopsy? ☐ Yes ☐ No	
Patients Treatment History: ☐ No treatment for this type of cancer (initial staging) ☐ Treatment with surgery alone for this type of cancer ☐ Treatment other than surgery alone for this cancer	Reason for study: ☐ Initial staging ☐ Restaging, surveillance ☐ Interim PET/CT for response-adapted therapy
Currently on chemotherapy: ☐ Yes ☐ No Completed chemotherapy: ☐ Yes ☐ No Date completed: _____	Currently on radiotherapy: ☐ Yes ☐ No Completed radiotherapy: ☐ Yes ☐ No Date completed: _____
Does patient have known cancer spread to other parts of the body beyond primary tumor (metastatic disease)?: ☐ Yes ☐ No	
Is there suspicion of recurrence or progression based on signs, symptoms, or imaging findings?: ☐ Yes ☐ No	
Prior Imaging Results and Dates:	
Additional Information:	

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.