# BRAIN FDG PET/CT ORDER FORM

**SCHEDULING**
P: 561.496.6935
F: 561.496.6936

**Not available in East Boynton and Delray Beach.**

*See back for addresses.*

**If faxing an order, please include:**
- Demographics
- Insurance card
- Clinical notes

| Appointment date and time | Check-in time | Patient DOB | O M O F |
|---|---|---|---|
| Patient name (as shown on insurance card) | Primary phone # | Secondary phone # | |
| Insurance name | Insurance ID # | Authorization # | |
| O Private O Government O No insurance | Study O FDG PET | Diagnosis O Alzheimer's - G30.9 O Dementia - F03.90 O Memory loss- R41.3 O Other ______ | |

| **(REQUIRED) Written diagnosis/reason/symptom for exam(s).** Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test. | **Clinical Decision Support (CDS)** **Required for Medicare Part B** | |
|---|---|---|
| | Modifier (determination) | G-code (vendor) |
| **Is the exam/procedure related to an injury?** O No O Yes **If yes** O Initial O Subsequent or O Sequela | | |

## INSURANCE REQUIREMENTS FOR PET/CT

**Complete and attach results if not at RAYUS Radiology FL Southeast**

- Date of onset of symptoms ______
- Diagnosis of clinical syndrome O Normal aging O Mild cognitive impairment (MCI) O Mild, moderate or severe dementia
- Mini mental status exam (MMSE) or similar test score ______
- Presumptive cause O Possible O Probable O Uncertain AD
- Neuropsychological testing performed. ______
- Structural imaging (MRI or CT) performed. ______
- Relevant laboratory tests (B12, thyroid hormone). ______
- Number and name of prescribed medications. ______

## MEDICARE/HUMANA INSURANCE REQUIREMENTS

The referring provider(s) must have documented the appropriate evaluation of the Medicare beneficiary. Providers should establish the medical necessity of an FDG PET scan by ensuring that the following information has been collected.

## PROCESS TO REVIEW WITH THE PATIENT

Once all criteria are met and the order and documentation are received, RAYUS Radiology will call the patient to schedule the study.

| **Patient consideration** O Arrange transportation | | | |
|---|---|---|---|
| **REPORTING METHOD** O Report only via fax ______ | O Provider portal | O CD with patient | |
| Provider name (print) | Provider location City/Zip | Phone # | Fax # |
| **Provider signature (required)** Do not use rubber stamp. | **NPI # (required for new providers)** | Date | |

RAYUS RADIOLOGY™

**BOCA RATON**
8142 Glades Rd.
Boca Raton, FL 33434

**BOCA RATON WEST**
23071 State Rd. 7
Boca Raton, FL 33428

**BOYNTON BEACH EAST**
1425 Gateway Blvd., Ste 100
Boynton Beach, FL 33426

**BOYNTON BEACH WEST**
6080 Boynton Beach Blvd., Ste 140
Boynton Beach, FL 33437

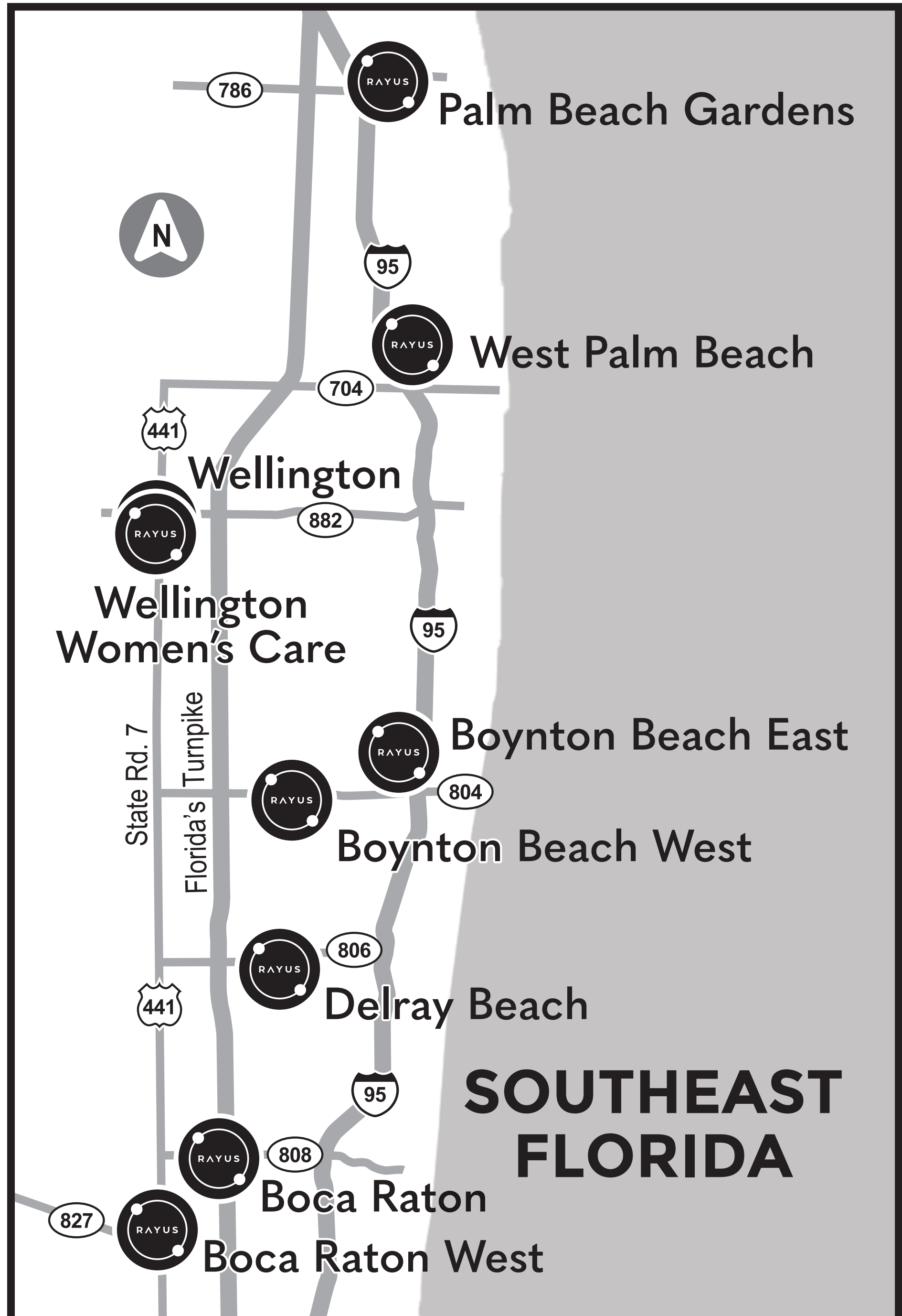
**DELRAY BEACH**
15340 Jog Rd., Ste 160
Delray Beach, FL 33446

**PALM BEACH GARDENS**
3601 PGA Blvd., Ste 100
Palm Beach Gardens, FL 33410

**WELLINGTON**
2565 S. State Rd. 7
Wellington, FL 33414

**WELLINGTON WOMEN'S CARE**
2863 State Road 7, Ste 400
Wellington, FL 33414

**WEST PALM BEACH**
1572 Palm Beach Lakes Blvd., Ste 2
West Palm Beach, FL 33401




RAYUSradiology.com/DCA