



MATER PET/CT CENTRE

*A public/private partnership between
Mater Misericordiae University Hospital and Mater Private Hospital*

*ECCLES STREET / DUBLIN 7 / IRELAND
TEL + 353 1 803 4970
FAX + 353 1 803 4989
EMAIL materpetct@materprivate.ie*

Hibernian Aviva Healthcare Prior Approval Form

Please find attached 4-page Hibernian Aviva prior approval form for a PET/CT Scan. This needs to be completed in full and signed by the **consultant in charge** (it must be signed by him/her only). Please note that **all relevant CT, histology, MRI etc reports must accompany this form.** Also, please attach a referral letter outlining the clinical indications for the scan, this referral should also include contact details for both the patient and the consultant.

When completed, please **fax or email** the attached form to the PET/CT unit at 01-8034989 or materpetct@materprivate.ie. The prior approval form will then be submitted immediately to Hibernian Aviva and the patient will be contacted with an appointment if Hibernian Aviva approve the claim. (This can sometimes take over 1 week). Please be aware that sending back an incomplete form can delay the patient's appointment, so kindly make sure all sections are completed.

Prior to a PET/CT Scan, the patient will need one day to prepare for the scan (by following a set diet).

If you have any other queries, please do not hesitate to contact the undersigned.

Kind regards,

Bernie/Barbara

PET/CT Secretary

Tel: 01 8034970

Fax: 01 8034989

Email: materpetct@materprivate.ie

If all of the pages are not received or are illegible, please don't hesitate to contact us

PETCT PRE AUTHORISATION REQUEST FORM

From:

Referring Hospital Name: _____

Contact Details for PETCT Centre:

Proposed location for PETCT _____

Telephone: (_____) _____ Extn. _____

Fax: (_____) _____

E-Mail: _____

Question	Response
PATIENT	
Patient Section	
Policy Holder Name	
Policy Holder Address	
Membership Number	
Plan Level and name	
Patient Name	
Patient Relationship to Policy Holder	
Patient Date of Birth	
Proposed Date of Treatment	

Consultant & Medical Section	
Nature of symptoms being investigated via PETCT scan	
Date of onset of symptoms, which require PETCT Scan	
Previous history and treatment of these or any related symptoms, including any investigations their dates and results	Please attach history
Is this/treatment related to a Research Study ?	Yes or No
Please indicate Clinical reasons why a PETCT scan is being selected in preference to other diagnostic techniques?	
How may a PETCT scan assist/change the future treatment of the member?	
Is any further treatment required?	
Please supply details of PETCT Scan to be performed and the relevant procedure code	
Was patient transferred to this facility from another hospital for this scan? • If Yes please supply name of this hospital	Yes or No
Date of last PETCT (if applicable) and name of PETCT centre where performed	
Please attach	
Recent Consultant reports on CT Scan	
Recent Consultant reports on MRI Scan	
Recent Consultant reports on Histology Tests	

I hereby confirm that the PETCT scan for which pre authorization is being sought, is an integral part of a course of treatment.

Consultant/ Referring Doctor Signature _____

Consultant Hibernian Aviva Health Code _____

Date _____

HIBERNIAN AVIVA HEALTH PETCT CLINICAL INDICATORS

Please circle as appropriate

DESCRIPTION	Diagnosis	Staging		Recurrence	Therapy Control	Pre Surgery Evaluation
		Nodal	Metastatic			
		CODE				
Lung Cancer (NSCLC)		7701	7702	7703		
Lung Cancer (Small Cell)				7712	7713	
Solitary Pulmonary Nodule (SPN)	7720					
Pulmonary mass lesions - only those that are too risky to biopsy	7730					
Colorectal Cancer		7741	7742	7743		
Oesophageal Cancer	7750	7751	7752	7753		
Pancreatic Cancer				7763		
Malignant Melanoma		7771	7772	7773		
Lymphoma - Hodgkin's		7781	7782	7783	7784	
Lymphoma - High Grade Non Hodgkins		7791	7792	7793	7794	
Lymphoma - Low Grade Non Hodgkins		7801	7802	7803	7804	
Head Cancer		7811	7812	7813	7813	
Neck Cancer		7821	7822	7823	7824	
Cervical Cancer - limited to suspected remote metastases based on other imaging techniques		7831	7832	7833		
Unknown Primary Tumour	7840					
Breast Cancer -(not for axillary node evaluation)		7851	7852	7853	7854	
Brain Tumour				7863		
Ovarian Tumour & Cervical Cancer				7873		7875*
Bone & Soft Tissue Tumour				7883		
Differentiated Thyroid Cancer			7892			
Alzheimers Dementia - only where CT/MRI are negative	7900					
Myocardial Viability	7905					
Cardiomyopathy - differential diagnosis	7910					
Focal/Temporal Lobe Epilepsy						7925
Testicular Cancer**						7945**

*Ovarian Cancer - Restaging of previously treated women with a rising CA125 level, who have a negative or equivocal conventional imaging CT or MRI

**Testicular Cancer - restaging of men with previously treated disease for the purpose of detecting residual disease suspected recurrence or to determine the extent of recurrence

Part 2 – This part to be completed in full by the admitting doctor/consultant/GP

Patient's full name:

Please state the name of the person who referred patient to you:

Was the admission an emergency? Yes No

Was this a re-admission for the same condition? Yes No

Nature of symptoms:

Duration of symptoms:

When did the patient first consult you with these symptoms?

Reason for admission (admitting diagnosis):

Date of treatment (day/mth/yr):

Primary diagnosis:

Secondary diagnosis:

Please supply full description and details of tests/treatment supplied covered by this claim:

Please supply procedure name and applicable code:

Has the patient a history of these or any related symptoms? Yes No

If yes, please give the details and dates of the treatments prior to these admissions:

Is the admission/treatment related to a clinical research study? Yes No

Was the patient transferred from the hospital during this visit for any other investigations? Yes No

If yes, please supply name of the hospital and nature of test/treatment performed:

Is this claim related to any addictive condition? (e.g. alcohol dependence, drugs or other substance abuse) Yes No

If yes, please give details:

Is this claim related to any psychiatric condition? Yes No

If yes, please give details:

Is any further treatment required?

Was patient transferred on discharge to a nursing/convalescence home by you? Yes No

If yes, please supply details:

Consultant signature:

Date:

Doctor code:

Please attach relevant receipts.

Patient's name: _____

Scans – Out patient only

This section is for completion in the case of scans only

Which hospital/approved centre carried out the scan?

Date of MRI/CT/PET* scan (day/mth/yr):

Reason for referral:

MRI/CT procedure codes:

Consultant signature:

Date:

Doctor code:

Please attach relevant receipts.

*Requires pre-certification from Hibernian Aviva Health

Part 3 – Hospital details

This part to be completed in full by the hospital.

Name of hospital/place of treatment:

Date of admission (day/mth/yr):

Date of discharge (day/mth/yr):

Please indicate type of stay:

Private in patient

Semi-private in patient

Day case in a hospital

Procedure/treatment in an out-patient department

Public ward