cERianna™
(FLUOROESTRADIOL F 18) INJECTION

Patient Referral Form

Live Support (833) 946-6392 (Mon–Fri, 8 am to 6 pm ET)
Fax (833) 718-3297

Patient Information *(required)*

Patient Name:		DOB:	Sex: ☐M ☐F
Address:		City:	State: ZIP:
Home Phone:	Cell Phone #:		Email:
Language: ☐ English ☐ Spanish ☐ Other:		Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening	

Patient Insurance Information *(required)*

PLEASE INCLUDE COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD(S)

Primary Insurance:	Group #:	Policy #:
Primary's Phone #:	Subscriber's Name *(if not self):*	
Subscriber's Employer:	Subscriber's Relationship to Patient *(if not self):*	
Secondary Insurance:	Group #:	Policy #:
Secondary's Phone #:	Secondary's Type:	

Prescriber's Information *(required)*

Prescriber's Name:		SLN #:	NPI #:
Practice Name:		Tax ID #:	PTAN #:
Address:		City:	State: ZIP:
Phone #:	FAX:		Email:
Office Contact Name:		Preferred Method of Contact: ☐ Phone ☐ Email ☐ FAX	

Medical Information *(required)*

ICD-10 Diagnosis Code *(Check Code for Malignant Neoplasm of the Breast):*

☐ C50.011 Nipple & Areola, Right Female	☐ C50.012 Nipple & Areola, Left Female
☐ C50.211 Upper-inner Quadrant, Right Female	☐ C50.212 Upper-inner Quadrant, Left Female
☐ C50.311 Lower-inner Quadrant, Right Female	☐ C50.312 Lower-inner Quadrant, Left Female
☐ C50.411 Upper-outer Quadrant, Right Female	☐ C50.412 Upper-outer Quadrant, Left Female
☐ C50.511 Lower-outer Quadrant, Right Female	☐ C50.512 Lower-outer Quadrant, Left Female

(Check Code for Secondary Malignant Neoplasm of the):

☐ C78.01 Right Lung	☐ C78.02 Left Lung
☐ C78.1 Mediastinum	☐ C78.2 Pleura
☐ C78.30 Unspecified Respiratory Organ	☐ C78.39 Other Respiratory Organs
☐ C79.31 Brain	☐ C79.51 Bone
☐ OTHER:	*Note: For Male Specific C50 Codes, please call the Support Center at (833) 946-6392*

Procedure Details *(Check Site of Service):*

- ☐ Free Standing Imaging Center
- ☐ Hospital Outpatient
- ☐ Hospital Inpatient
- Anticipated Date of Service:
- Site of Service Name & Location:
- Site of Service Phone #:
- NPI #:

CPT Procedure Code *(Check Code for Positron Emission Tomography (PET):*

☐ 78815 Skull base to mid-thigh w/CT ☐ 78816 Whole Body w/CT ☐ OTHER:

Prescriber's Signature *(required)*

By signing below, I certify that (a) the above-prescribed diagnostic procedure is medically necessary and, (b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or other patient information relating to the need for the above-prescribed diagnostic procedure, to the Cerianna Support Program ("Program") through GE Healthcare's authorized Program service provider, its employees, affiliates and their representatives, its business partners, agents, and contractors for the purpose of seeking information related to coverage for the agent and/or related procedure.

Prescriber's Signature:	Date:

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GE HealthCare