DaTscan™ Ioflupane I 123 Injection

# Patient Referral Form

Live Support (844) 225-1595 (Mon–Fri, 8 am to 6 pm ET)
Fax (844) 225-1596

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

## Prescriber's Information *(required)*

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

## Medical Information *(required)* DaTscan NDC: 17156-210-01

**ICD-10 Diagnosis Code**

☐ G20.A1 Parkinson's disease without dyskinesia, without fluctuations
☐ G20.A2 Parkinson's disease without dyskinesia, with fluctuations
☐ G20.B1 Parkinson's disease with dyskinesia, without fluctuations
☐ G20.B2 Parkinson's disease with dyskinesia, with fluctuations
☐ G25.0 Essential Tremor
☐ G31.83 Dementia with Lewy Bodies
☐ OTHER:

**Procedure Details** *(Check Site of Service)*:

☐ Free Standing Imaging Center
☐ Hospital Outpatient
Anticipated Date of Service:

**Site of Service Details:**

Name:
Location:
NPI:
Contact:
Phone #:
Email:

**HCPCS/CPT® Code** *(Check Code for Single-Photon Emission Computed Tomography (SPECT):*

☒ A9584 Iodine I-123 Ioflupane, up to 5 millicuries ☐ 78803 Single Area SPECT ☐ 78830 Single Area SPECT w/ CT

## 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 DaTscan 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:

GE HealthCare

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