



Patient Referral Form

Live Support Mon-Fri, 8 am to 6 pm ET
Phone (800) 729-0701 Fax (800) 255-6675
Email: gehealthcare@pharmacord.com
Online Enrollment Site: gehealthcare-hcp.pharmacord.com

Scan to Enroll



Patient Information (required)

Patient Name:	DOB:	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F
Address:	City:	State:	ZIP:
Phone:	Email:		

Patient Insurance Information (required)

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: <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> FAX	

Medical Information (required)

Flyrcado NDC: 0407-8787-01

ICD-10 Diagnosis Code

<input type="checkbox"/> I20.81 Angina Pectoris w/MVD	<input type="checkbox"/> I25.89 Chronic Ischemic - Other
<input type="checkbox"/> I20.89 Angina Pectoris - Other	<input type="checkbox"/> I25.9 Chronic Ischemic - Unspecified
<input type="checkbox"/> I24.81 Microvascular Dysfunction	<input type="checkbox"/> I44.7 Left BB Block - Unspecified
<input type="checkbox"/> I24.89 Acute Ischemic - Other	<input type="checkbox"/> I48.11 Persistent A-Fib
<input type="checkbox"/> I25.10 Atherosclerotic HD w/AP	<input type="checkbox"/> I48.19 Persistent A-Fib - Other
<input type="checkbox"/> I25.118 Atherosclerotic HD w/AP	<input type="checkbox"/> I48.20 Chronic A-Fib - Unspecified
<input type="checkbox"/> I25.6 Silent Myocardial Ischemia	<input type="checkbox"/> R93.1 Diag Imaging Abn findings
<input type="checkbox"/> OTHER:	<input type="checkbox"/> R94.31 Abn electrocardiogram ECG/EKG

Imaging Location (Check or write):

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

HCPCS: A9611 Flurpiridaz F-18, diagnostic, 1 millicurie

CPT® Code (Check Code for Positron Emission Tomography (PET):

<input type="checkbox"/> 78430 Single Study w/ CT	<input type="checkbox"/> 78431 Rest & Stress w/ CT	<input type="checkbox"/> +78434 Absolute quant of myocardial blood flow	<small>Coding of Additional Metabolic Evaluation Study may be dependent on the payor and/or protocol. Please contact your dedicated Field Reimbursement Manager for comprehensive support.</small>
<input type="checkbox"/> 78491 Single Study	<input type="checkbox"/> 78492 Rest & Stress	<input type="checkbox"/> Additional Metabolic Evaluation Study (FDG) →	

For Stress Testing 93015 - 93018 will be checked for authorization requirements

Prescriber or Authorized Representative's Signature & Checkbox (required)

By signing below, I attest that (a) the above-prescribed diagnostic procedure is medically necessary and that the information is accurate to the best of my knowledge; and (b) I have obtained from this patient, or his/her personal representative, the necessary authorizations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable federal and state privacy laws and regulations, to disclose the patient's personal and medical information relating to the need for the above-prescribed diagnostic procedure, to GE HealthCare and its employees, affiliates and their representatives, its business partners, agents, and contractors, including the Flyrcado Support Program ("Program") through GE HealthCare's authorized Program service provider, for the purpose of benefits verification and investigation, prior authorization, claims review and otherwise verifying coverage for GE HealthCare's products and/or related procedures.

I attest that I, the Prescriber or Authorized Representative, am or am not both the prescribing and billing licensed healthcare professional for this Flyrcado order.

Prescriber or Authorized Representative's Signature:	Date:
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