Registration and Inventory of Medical Equipment
Fixed Positron Emission Tomography Scanners
January 2010

Instructions This is the legally required "Registration and Inventory of Medical Equipment" (G.S. § 131E-177) for Fixed Positron Emission Tomography (PET) scanners. Please complete all sections of this Registration and Inventory Form and return by **5:00 p.m. on Friday, January 29, 2010**. We encourage you to email the completed and signed form in a Portable Document Format (pdf) file to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov. If it is not possible to email the completed form, you can mail it to Carol G. Potter, Medical Facilities Planning Section, 701 Barbour Drive, Raleigh, N.C. 27603. If you have questions, you can send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call the Medical Facilities Planning Section at (919) 855-3865. Thank you!

Section One Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

   _____
   (Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

   _____
   (Street and Number)

   _____ (_____) _____
   (City) (State) (Zip) (Phone Number)

3. Chief Executive Officer who is certifying the information in this registration form:

   _____
   (Name) (Title)

   _____
   (Street and Number) (City) (State) (Zip)

   _____ _____
   (Phone) (Email)

4. Information Compiled or Prepared by: (Name)_____

   Phone (_____)_____ E-mail _____

Section Two Equipment Information

Time Period for Report: ❑ 10/01/2008 – 9/30/2009 ❑ Other time period: _____

(Please make additional copies of pages of this form as needed.)

	PET Scanner Information	
Manufacturer		
Model #		
Serial or I.D. #		
Date of purchase		
Purchase price		
Certificate of Need Project ID		
Address Where Scanner is Located		
Total # of procedures: _____	# Inpatient Procedures	# Outpatient Procedures

* PET **procedure** means a single discrete study of one patient involving one or more PET scans. PET **scan** means an image-scanning sequence derived from a single administration of a PET radiopharmaceutical, equated with a single injection of the tracer. One or more PET scans comprise a PET procedure.

Section Three PET Procedures by CPT Code

Please write the number of procedures provided by CPT Code during the time period of this report.

CPT Code	CPT Description	# of Procedures
78608	Brain imaging – metabolic evaluation	
78609	Brain imaging – perfusion evaluation	
78459	Myocardial imaging - metabolic evaluation	
78491	Myocardial imaging – perfusion; single study at rest or stress	
78492	Myocardial imaging – perfusion; multiple studies at rest and/or stress	
78811	Tumor imaging – limited area (eg, chest, head/neck)	
78812	Tumor imaging – skull base to mid-thigh	
78813	Tumor imaging – whole body	
78814	Tumor imaging – with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (eg, chest, head/neck)	
78815	Tumor imaging with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid-thigh	
78816	Tumor imaging with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body	
Please list other CPT codes and number of procedures billed for (make a copy of this page if needed)		
	Total Number of Procedures	

Name of entity that acquired the equipment (from page one) _____

Section Four **Patient Origin Data**

Please provide the county of residence for each patient who received PET scanner services during the time period of this report. This data should only reflect the number of patients, not number of scans, and should not include other radiopharmaceutical or supply charge codes. Count each patient only once. The number of patients in this table should match the number of PET procedures reported on page two of this report.

County in which Service was provided: _____

County	Number of Patients	County	Number Of Patients	County	Number of Patients
1. Alamance		41. Guilford		81. Rutherford	
2. Alexander		42. Halifax		82. Sampson	
3. Alleghany		43. Harnett		83. Scotland	
4. Anson		44. Haywood		84. Stanly	
5. Ashe		45. Henderson		85. Stokes	
6. Avery		46. Hertford		86. Surry	
7. Beaufort		47. Hoke		87. Swain	
8. Bertie		48. Hyde		88. Transylvania	
9. Bladen		49. Iredell		89. Tyrrell	
10. Brunswick		50. Jackson		90. Union	
11. Buncombe		51. Johnston		91. Vance	
12. Burke		52. Jones		92. Wake	
13. Cabarrus		53. Lee		93. Warren	
14. Caldwell		54. Lenoir		94. Washington	
15. Camden		55. Lincoln		95. Watauga	
16. Carteret		56. Macon		96. Wayne	
17. Caswell		57. Madison		97. Wilkes	
18. Catawba		58. Martin		98. Wilson	
19. Chatham		59. McDowell		99. Yadkin	
20. Cherokee		60. Mecklenburg		100. Yancey	
21. Chowan		61. Mitchell			
22. Clay		62. Montgomery		101. Georgia	
23. Cleveland		63. Moore		102. South Carolina	
24. Columbus		64. Nash		103. Tennessee	
25. Craven		65. New Hanover		104. Virginia	
26. Cumberland		66. Northampton		105. Other States	
27. Currituck		67. Onslow		106. Other (specify)	
28. Dare		68. Orange		**Total Number of Patients Served by Your Facility's PET Scanners**	
29. Davidson		69. Pamlico			
30. Davie		70. Pasquotank			
31. Duplin		71. Pender			
32. Durham		72. Perquimans			
33. Edgecombe		73. Person			
34. Forsyth		74. Pitt			
35. Franklin		75. Polk			
36. Gaston		76. Randolph			
37. Gates		77. Richmond			
38. Graham		78. Robeson			
39. Granville		79. Rockingham			
40. Greene		80. Rowan			

Name of entity that acquired the equipment (from page one) _____

Section Five Reimbursement/Payment Source

Please provide the source of reimbursement/payment for PET procedures. Total procedures should equal the total number of procedures reported on page two of this report.

Primary Payer Source	Number of Procedures
Self Pay	
Medicare & Medicare Managed Care	
Medicaid	
Commercial Insurance	
Managed Care	
Unreimbursed Care (Indigent/Charity)	
Other (Specify)	
TOTAL	

Section Six Certification and Signature

The undersigned Chief Executive Officer or other approved signatory certifies the accuracy of the information contained on all pages of this form.

Print name _____

Signature _____

Date signed _____

Please return the completed form by 5:00 p.m. Friday, January 29, 2010 by email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov (pdf file), or mail to Carol G. Potter, Medical Facilities Planning Section, 701 Barbour Drive, Raleigh, N.C. 27603. If you have questions, send an email to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov or call (919) 855-3865.

Thank you!

Name of entity that acquired the equipment (from page one) _____