



Registration and Inventory of Medical Equipment
Fixed Positron Emission Tomography Scanners
January 2015

Instructions

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for fixed positron emission tomography scanners. Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 30, 2015**.

1. Complete and sign the form
2. Return the form by one of two methods:
 - a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov
 - b. Mail the form to Kelli Fisk, Medical Facilities Planning Branch, 2714 Mail Service Center, Raleigh, NC 27699-2714.

Note: Fixed equipment operated in a facility licensed under a hospital should be reported on that hospital’s license renewal application, and not duplicated on this form.

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Section 1: 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 or approved designee who is certifying the information in this registration form:

(Name)

(Title)

(Street and Number)

(City)

(State) (Zip)

(_____) _____

(Phone Number)

(Email)

4. Information Compiled or Prepared by: _____

(Name)

(_____) _____

(Phone Number)

(Email)



Section 2: Equipment and Procedures Information

Time Period for Report: 10/01/2013 – 9/30/2014 Other time period: _____

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

PET Scanner Information		
Manufacturer		
Model Number		
Serial or I.D. Number		
Date of purchase		
Purchase price		
Certificate of Need Project ID		
Service Site Information: Please include all of the information requested for each location.	Service Site _____	
	Address _____	
	City, State, Zip _____	
	County _____	
Total number of procedures*: _____	Inpatient Procedures*	Outpatient Procedures*

* 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. PET **procedure** means a single discrete study of one patient involving one or more PET scans.

Name of entity that acquired the equipment (from page 1) _____



Section 3: 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	Number 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 1) _____



Section 4: 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 2 of this report.

County in which service was provided: _____

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

Name of entity that acquired the equipment (from page 1) _____



Section 5: 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 2 of this form.

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 6: Certification and Signature

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

Signature _____

Print Name _____

Date signed _____

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