MED SOLUTIONS
INTELLIGENT COST MANAGEMENT

PRI-SM

MRA/CTA Head & Neck Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID: 72-0702002	
Address: 1501 Kings Highway	City: Shreveport	ST: LA	Zip: 71130-3932
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name: LSU Health Sciences Center		Facility Tax ID: 72-0702002	
Address: 1501 Kings Hwy	City: Shreveport	ST: LA	Zip: 71130-3932
Phone #: 318-675-7074	Fax #: see bottom of page	☐ RETRO Date of Service:	

Clinical Information

Please circle all that apply: **CPT®** Code(s): **CTA HEAD:** 70496 **CTA NECK:** 70498 **MRA HEAD:** 70544 70545 70546
MRA NECK: 70547 70548 70549 OTHER_____

ICD-9: ☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1.	Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_____			☐ None	☐ Don't Know		
2.	Type of most recent documented contact with physician?	☐ Hospital	☐ Office visit	☐ Phone call with office staff	☐ Phone call with physician	☐ Email	☐ Other	☐ Don't Know
3.	Is there previous head imaging for this problem within the past three years?				☐ Yes	☐ No	☐ Don't Know	
4.	Date of previous head imaging?	Date: _____			☐ Other	☐ None	☐ Don't Know	
5.	Has there been recent onset of hemiplegia?				☐ Yes	☐ No	☐ Don't Know	
6.	Is dementia or Alzheimer's disease suspected?	☐ Dementia	☐ Alzheimers		☐ Both	☐ Neither	☐ Don't Know	
7.	Has there been a new onset of epileptic seizure?				☐ Yes	☐ No	☐ Don't Know	
8.	Is there a history of migraines?				☐ Yes	☐ No	☐ Don't Know	
9.	Has there been persistent unresponsive vertigo despite several days of treatment?				☐ Yes	☐ No	☐ Don't Know	
10.	Has a trial of physician-directed treatment been completed?				☐ Yes	☐ No	☐ Don't Know	
11.	Has physician-directed treatment of at least 3 weeks failed to help the problem?				☐ Yes	☐ No	☐ Don't Know	
12.	When did treatment start? ☐ Less than 1 month ago ☐ More than 1 month ago			☐ No Treatment ☐ Does not apply		☐ Don't Know		
13.	Can the patient walk normally?				☐ Yes	☐ No	☐ Don't Know	
14.	Is there a known brain tumor?				☐ Yes	☐ No	☐ Don't Know	
15.	Has there been a known (not suspected) recent stroke or TIA?				☐ Yes	☐ No	☐ Don't Know	
16.	Is there a family history of 1st degree relatives with a brain aneurysm?				☐ Yes	☐ No	☐ Don't Know	
17.	Is there previous MRI or CT head imaging for this problem?				☐ Yes	☐ No	☐ Don't Know	
18.	Has there been a recent evaluation by a neurologist or neurosurgeon?				☐ Yes	☐ No	☐ Don't Know	

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other _____

Signature

Please Sign and Date Below: Responsible Contact: Name of Attending Physician:_____

Print Name: _____ **Date:** _____

Sign Name: _____ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

Fax#: For Approvals 318-675-6212 For Denials 318-675-7073