MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

CT Chest, Abdomen & Pelvis Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, additional clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax forms *(non urgent requests only)* to **888.693.3210.**

URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.

Member

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

Physician

Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:	Tax ID:		
Address:		City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:		

Facility

Facility Name:		Facility Tax ID:	
Address:		City:	ST:	Zip:
Phone #:	Fax #:	NPI:	☐ RETRO Date of Service:

Clinical

Check all applicable CPT® code(s) (REQUIRED): **CT ABD** : ☐ 74150 ☐ 74160 ☐ 74170 **CT PELVIS:** ☐ 72192 ☐ 72193 ☐ 72194 **CT ABDOMEN AND PELVIS:** ☐ 74176 ☐ 74177 ☐ 74178 **CT CHEST**: ☐ 71250 ☐ 71260 ☐ 71270 **CTA CHEST** : ☐ 71275 ☐ Other _____

ICD-9 Code (s) (REQUIRED):

1. Date of most recent office visit or other documented contact with physician:
   Date: _____ (mm/dd/yyyy) ☐ 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 abdominal or pelvic pain present
   ☐ Yes ☐ No ☐ Don't Know
4. Where is the location of pain? Above the Umbilicus or below?
   - ☐ Above
   - ☐ Below
   - ☐ Both
   - ☐ Does not have pain
   - ☐ Don't Know
5. Is there left lower quadrant pain?
   ☐ Yes ☐ No ☐ Don't Know

6. Has there been abdominal or pelvis surgery within the past year?
☐ Yes ☐ No ☐ Don't Know

7. Is fever present?
☐ Yes ☐ No ☐ Don't Know

8. Is there an elevated white blood cell count?
☐ Yes ☐ No ☐ Don't Know

9. Is this to evaluate a hernia?
☐ Yes ☐ No ☐ Don't Know

10. Are there unclear findings of previous imaging studies (CT, MRI, Ultrasound, X-ray)?
☐ Yes ☐ No ☐ Don't Know

11. Has there been unexplained or unintentional weight loss?
☐ Yes ☐ No ☐ Don't Know

12. Is there a history of diverticulitis?
☐ Yes ☐ No ☐ Don't Know

13. Has treatment with antibiotics been done in the past week?
☐ Yes ☐ No ☐ Don't know

14. Is this for cancer diagnosis?
☐ Yes ☐ No ☐ Don't Know

15. Is there evidence of cancer in the chest?
☐ Yes ☐ No ☐ Don't Know

16. Is there a new nodule or mass on chest x-ray or imaging study?
☐ Yes ☐ No ☐ Don't Know

17. Was a chest x-ray done within the last 4 weeks and read by a radiologist?
☐ Yes ☐ No ☐Don't Know

18. Has a chest CT been done within the past year?
☐ Yes ☐ No ☐Don't Know

19. Is chest pain present?
☐ Yes ☐ No ☐Don't Know

20. Has a D-dimer been done?
☐ Normal ☐ Abnormal ☐Test Not Done ☐ Don't Know

Who will be the responsible contact for additional information, if requested, or questions concerning this request?

Print Name:_____

Additional Information/Comments:

Submitter

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

Sign and Date Below:

Print Name:_____

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