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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.

Patient First Name:			Patient Last Name:			
DOB: Member ID:		D:	Group #:		Health Plan:	
DOB: Address:			City:		ST:	Zip:
Physician First Name:			Physician Last Name:			
Primary Specialty: Address: Phone #: Fax #:		NPI:	Tax ID:			
		City:			ST:	Zip:
			Contact Email:		I	
Eacility Name:						
Address:			-		ST:	Zip:
Phone #: Fax #:			NPI:			ice:
Check all applicable CPT [®] code(s) (REQUIRED): CT CHEST: 71250 71260 71270 CTA CHEST 71275 CT NECK: 70490 70491 70492 Other:						
	DOB: Address: Physician First Name: Primary Specialty: Address: Phone #: Facility Name: Address: Phone #: Check all applicable CPT® code CT NECK: 70490 70490 ICD-9 Code (s) (REQUIRED): 1. Date of most recent office vis Date: 2. Type of most recent docume Hospital Office visit Phone call with office sta Phone call with physician Email Other Don't know 3. Is this for cancer diagnosis? Yes No Don't know 3. Is there evidence of cancer ir Yes No Don't K 4. Is there a new nodule or mas Yes No Yes No On't K 6. Was a chest x-ray done withi Yes No On't K 7. Has a chest CT been done w Yes No Yes No	DOB: Member II Address: Physician First Name: Primary Specialty: Address: Phone #: Fax #: Facility Name: Address: Phone #: Fax #: Facility Name: Address: Phone #: Fax #: Check all applicable CPT® code(s) (REQU CT NECK: 70490 OTNECK: 70490 ICD-9 Code (s) (REQUIRED): 1. Date of most recent office visit or other of Date:	DOB: Member ID: Address: Physician First Name: Primary Specialty: NPI: Address: Phone #: Facility Name: Fax #: Address: Phone #: Facility Name: Address: Phone #: Fax #: Check all applicable CPT [®] code(s) (REQUIRED): CT CHEST : [CT NECK: 70490 Phone #: Fax #: Check all applicable CPT [®] code(s) (REQUIRED): CT CHEST : [CT NECK: 70490 I. Date of most recent office visit or other documented contact with physician? I. Date of most recent documented contact with physician? Bone call with office staff Phone call with office staff Phone call with physician Email Other Don't Know 3. Is this for cancer diagnosis? Yes No Don't Know 5. Is there a new nodule or mass on chest x-ray or imaging study Yes No Yes No So Don't Know 6. Was a chest x-ray done within the last 4 weeks and read by a 1 Yes No Don't Know	DOB: Member ID: Group #: Address: City: Physician First Name: Physician Last Name: Primary Specialty: NPI: Address: City: Phone #: Fax #: Contact Email: Facility Name: Fax #: Address: City: Phone #: Fax #: Check all applicable CPT® code(s) (REQUIRED): CT CHEST : 71250 Check all applicable CPT® code(s) (REQUIRED): CT CHEST : 71260 CT NECK: 70490 70492 Other:	DOB: Member ID: Group #: Address: City: Physician First Name: Physician Last Name: Primary Specialty: NPI: Address: City: Phone #: Fax #: Contact Email: Facility Name: Facility Tax ID: Address: City: Phone #: Fax #: Contact Email: Address: City: Phone #: Fax #: NPI: RETRO Check all applicable CPT® code(s) (REQUIRED): CT CHEST : 71250 Check all applicable CPT® code(s) (REQUIRED): CT CHEST : 71250 TNECK: 70490 70491 COT NECK: 70490 70492 Other:	DOB: Member ID: Group #: Health Plan: Address: City: ST: Physician First Name: Physician Last Name: Physician Last Name: Primary Specialty: NPI: Tax ID: Address: City: ST: Phone #: Fax #: Contact Email: Facility Name: Fax #: Contact Email: Facility Name: Fax #: NPI: ST: Address: City: ST: Phone #: Fax #: NPI: Check all applicable CPT ⁶ code(s) (REQUIRED): CT CHEST : 71260 71270 CTA CHES' Check all applicable CPT ⁶ code(s) (REQUIRED): CT CHEST : 71260 71270 CTA CHES' CT NECK: 70490 70491 70492 Other: Contact Email: IDD-9 Code (s) (REQUIRED): Inm/dd/yyyy) None Don't Know Don't Know 1. Date of most recent office visit or other documented contact with physician: Don't Know Don't Know 2. Type of most recent documented contact with physician: Don't Know Don't Know St this for cancer diagnosis? St this for cancer diagnosis? Sth

IMPORTANT WARNING: This information is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this fax by error, please notify the phone number above immediately and destroy the fax. © 2011 MedSolutions, Inc. (PRI-SM)

MED	SOLUT	IONS
	NTELLIGENT COST M	ANAGEMENT

Stress Echo Imaging Request

□ MD □ RN □ LPN □ PA □ NP □ Other

Patient Name:	DOB:	(Page 2 of 2)
9. Has a D-dimer been done?		
10. Is this test to image the spine (neck bones or spinal cord)?		
11. Is cancer suspected? Suspected, not confirmed Known History Not Suspect	ted 🔲 Don't Know	
12. Is there a neck a mass?		
13. Is the neck mass painful?		
14. Has there been difficulty or pain with swallowing?		
15. Is a thyroid problem suspected?		
16. Has a neck ultrasound been:		
17. Is neck surgery planned?		
Who will be the responsible contact for additional information, if requester Print Name:	ed, or questions concerning this request?	
Additional Information/Comments:		
Check the appropriate box describing you: Ordering Physician] Facility 🔲 Other	
Sign and Date Below:		

Print Name:

Sign Name: