MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

CT Chest/Neck 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 CHEST : ☐ 71250 ☐ 71260 ☐ 71270 CTA CHEST ☐ 71275

CT NECK: ☐ 70490 ☐ 70491 ☐ 70492 ☐ 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 this for cancer diagnosis?
   ☐ Yes ☐ No ☐ Don't Know

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

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

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

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

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

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

10. Is this test to image the spine (neck bones or spinal cord)?
☐ Yes ☐ No ☐ Don't Know

11. Is cancer suspected?
☐ Suspected, not confirmed ☐ Known History ☐ Not Suspected ☐ Don't Know

12. Is there a neck a mass?
☐ Yes ☐ No ☐ Don't Know

13. Is the neck mass painful?
☐ Yes ☐ No ☐ Don't know

14. Has there been difficulty or pain with swallowing?
☐ Yes ☐ No ☐ Does Not Apply ☐ Don't Know

15. Is a thyroid problem suspected?
☐ Yes ☐ No ☐ Don't Know

16. Has a neck ultrasound been:
☐ Done ☐ Planned ☐ Neither ☐ Don't Know

17. Is neck surgery planned?
☐ Yes ☐ No ☐ 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**