MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

CT Maxillofacial & 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 NECK : ☐ 70490 ☐ 70491 ☐ 70492 **CT Maxillofacial**: ☐ 70486 ☐ 70487 ☐ 70488 ☐ 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 head or neck cancer suspected?
   ☐ Yes ☐ No ☐ Don't Know
4. Is there a history of headaches?
   ☐ Yes ☐ No ☐ Don't Know
5. Is there a history of asthma?
   ☐ Yes ☐ No ☐ Don't Know
6. Is there a history of chronic sinusitis?
   ☐ Yes ☐ No ☐ Don't Know
7. Is this a repeat episode of chronic sinusitis?
   ☐ Yes ☐ No ☐ Don't Know
8. Are there findings of periorbital cellulitis?
   ☐ Yes ☐ No ☐ Don't Know

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)

Patient Name: ______________________________________ DOB: ______________

9. Has there been failure to improve with physician directed treatment?
☐ Yes ☐ No ☐ Don't Know

10. Has there been failure to improve after a 4 week trial of physician supervised treatment for sinusitis?
☐ Yes ☐ No ☐ Don't Know

11. Was a second antibiotic used if the first course of antibiotic treatment was unsuccessful?
☐ Yes ☐ No ☐ Don't know

12. Has a specialist evaluation been done?
☐ Ear Nose and Throat
☐ Allergist
☐ Pulmonologist
☐ Neurologist
☐ Neurosurgeon
☐ No
☐ Other
☐ Don't Know

13. Is this test to image the spine?
☐ Yes ☐ No ☐ Don't Know

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

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

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

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

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

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

20. 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 ____________________________

Print Name:____

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

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)