

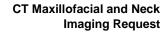
## CT Maxillofacial & Neck Imaging Request

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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.

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Member	Patient First Name:			Patient Last Name:				
	DOB:	Member II	D:	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 :							





Patient Name:	DOB: (Page 2 of 2)						
9. Has there been failure to improve with physician dire  Yes No Don't Know	cited treatment?						
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	☐ Ear Nose and Throat ☐ Allergist ☐ Pulmonologist ☐ Neurologist ☐ Neurosurgeon ☐ No ☐ Other ☐ Don't Know  Is this test to image the spine?						
14. Is cancer suspected?							
<ul> <li>Suspected, not confirmed ☐ Known History ☐ Not Suspected ☐ Don't Know</li> <li>15. Is there a neck a mass?</li> <li>☐ Yes ☐ No ☐ Don't Know</li> </ul>							
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:							
Check the appropriate box describing you:   Ordering	Physician						
Print Name:							
Sign Name:	MD RN LPN PA NP Other						