MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

CT Spine Imaging Request

Completing this survey can provide quicker turnaround. Additional comments can be made in the comments section. We encourage you to electronically forward relevant data/notes, especially previous imaging results. This form and all data submitted are legally considered an extension of the medical record with regard to privacy and accuracy. Any inconsistencies on this survey compared with the office medical record should be explained in the comments section. 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): C-Spine: ☐ 72125 ☐ 72126 ☐ 72127 **T-Spine**: ☐ 72128 ☐ 72129 ☐ 72130 **L-Spine**: ☐ 72131 ☐ 72132 ☐ 72133 ☐ 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. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?

   Date _________________(mm/dd/yyy)
   - ☐ This is the first visit for this episode
   - ☐ Don't Know
   - ☐ Free Text: ____________________

4. Has a specialist evaluation been performed?
   ☐ Yes ☐ No ☐ Don't Know

5. Did the specialist generate this request?
   ☐ Yes ☐ No ☐ Don't Know

6. Has there been a recent head or neck trauma?
   ☐ Yes ☐ No ☐ Don't Know

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7. In the last two months, has there been significant trauma to the spine involving:
   - ☐ A motor vehicle accident (MVA)
   - ☐ A fall from a height
   - ☐ Any fall landing on the head
   - ☐ A head trauma with loss of consciousness
   - ☐ Other injury or trauma: ______________
   - ☐ No injury trauma
   - ☐ Don't know

8. Has there been persistent neck pain since injury?
   ☐ Yes ☐ No ☐ Don't Know

9. Is this request for a CT- myelogram or discogram?
   ☐ Yes ☐ No ☐ Don't Know

10. Is there an abnormal neurology exam?
    ☐ Yes ☐ No ☐ Don't Know

11. Is there a personal history of cancer other than ordinary skin cancer?
    ☐ 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**

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