MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRA and CTA Head 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 results of previous imaging or tests. 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

Please check all CPT® Code(s) that apply (REQUIRED): MRA HEAD: ☐ 70544 ☐ 70545 ☐ 70546 **CTA HEAD:** ☐ 70496

Other_____

ICD-9 Code (Required Field):

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 there previous head imaging for this problem within the past three years?

   ☐ Yes ☐ No ☐ Know

4. Date of previous head imaging?
   - ☐ Date _____
   - ☐ Don't Know
   - ☐ Other
   - ☐ None

5. Has there been recent onset of hemiplegia?

   ☐ Yes ☐ No ☐ Don't Know

6. Is Dementia or Alzheimer's disease suspected?
   - ☐ Dementia
   - ☐ Alzheimer's
   - ☐ Both
   - ☐ Neither
   - ☐ Don't Know

7. Has there been a new onset of epileptic seizure?
   ☐ Yes ☐ No ☐ Don't Know

8. Is there a history of migraines?
   ☐ Yes ☐ No ☐ Don't Know

9. Has there been persistent unresponsive vertigo despite several days of treatment?
   ☐ Yes ☐ No ☐ Don't Know

10. Has a trial of physician-directed treatment been completed?
    ☐ Yes ☐ No ☐ Don't Know

11. Has physician-directed treatment of at least 3 weeks failed to help the problem?
    ☐ Yes ☐ No ☐ Don't Know

12. When did treatment start?
    - ☐ Less than 1 month ago
    - ☐ More than 1 month ago
    - ☐ No Treatment
    - ☐ Does not apply
    - ☐ Don't Know

13. Can the patient walk normally?
    ☐ Yes ☐ No ☐ Don't Know

14. Is there a known brain tumor?
    ☐ Yes ☐ No ☐ Don't Know

15. Has there been a known (not suspected) recent stoke or TIA?
    ☐ Yes ☐ No ☐ Don't Know

16. Is there a family history of 1st degree relatives with a brain aneurysm?
    ☐ Yes ☐ No ☐ Don't Know

17. Is there a previous MRI or CT head imaging for this problem?
    ☐ Yes ☐ No ☐ Don't Know

18. Has there been a recent evaluation by a neurologist or neurosurgeon?
    ☐ 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**