Louisiana Medicaid
Radiology Precertification Reference

Introduction:

Effective February 15, 201O Louisiana Medicaid is requiring precertification for advanced imaging of outpatients. For the purpose of precertification advanced imaging is defined as:

- CT
- MR
- Nuclear Medicine, Cardiac Studies

Lists of CPT codes affected are contained in this guide. Since CPT codes and the precertification program will change over time, this reference guide will also be available on the website shown below and notices will be sent out when updates are made.

http://www.sh.lsuhsc.edu/raddept/lamedicaid.htm

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Louisiana Medicaid Announces Radiology Utilization Management (RUM) Program

Louisiana Medicaid will implement Radiology Utilization Management (RUM) to promote the health of Medicaid recipients by ensuring appropriate utilization of Department-defined high-tech imaging studies by Medicaid providers and recipients. Medicaid will partner with MedSolutions Inc. (MSI), to provide prior authorization, monitoring and management of medical imaging services.

Beginning with date of service February 15, 2010, primary care and specialty care providers will be required to request prior authorization for non-emergency outpatient Magnetic Resonance (MR), Computed Tomography (CT), and Nuclear Cardiac imaging. Reimbursement to the rendering provider will be contingent on prior authorization.

Providers will be receiving information from MedSolutions, Inc. detailing the prior authorization procedures along with invitations to attend webinars to learn more about the program. Information will also be available for providers via a link on the Louisiana Medicaid website, www.lamedicaid.com, remittance advice messages, and other forms of communication. Providers should continue to monitor the Medicaid website for the most up-to-date information regarding this program.

Click on the following link to open listing of RUM CPT Codes:
LA Medicaid specific RUM CPT Codes

Note:
Information regarding the RUM program can be found by following the link http://www.medsolutions.com/implementation/ladhh/index.html to access the program announcement letter, quick reference guide, and a schedule for web-based orientation sessions.

January 28, 2010

Procedure:

Louisiana Medicaid has contracted with MedSolutions Inc. to manage the precertification program. Requests for approval and other correspondence concerning the program will go to MedSolutions. There are three methods to submit a request for approval; phone, fax and web. We will utilize the fax method at this time. Since the precertification requirement is for outpatient procedures have been developed for:

1. Patients seen in a clinic and scheduled for an exam
2. Patients being discharge and scheduled for a follow-up outpatient exam.

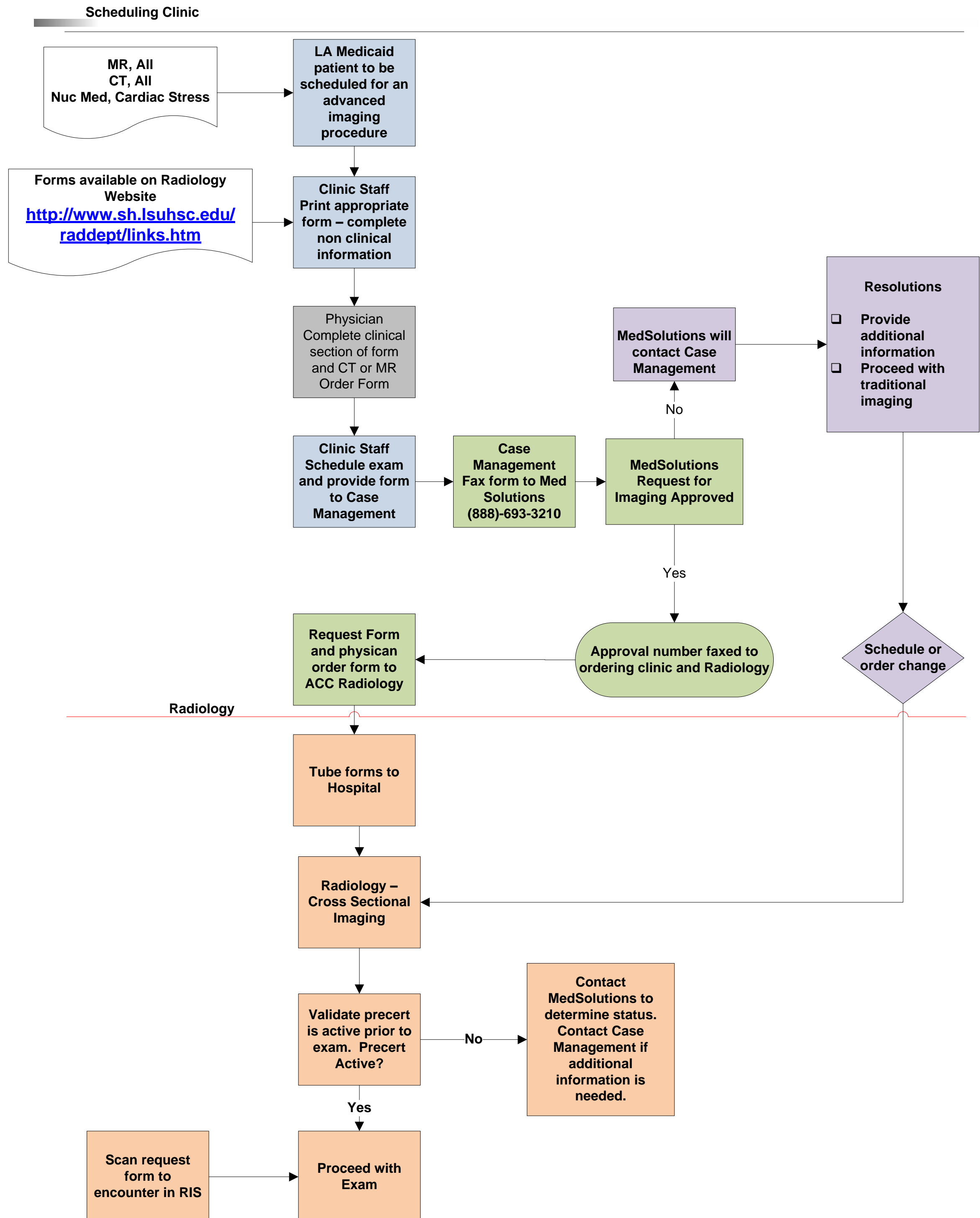
Precertification is valid for 60 days. If the exam is to be scheduled beyond 60 days, please contact Radiology at 56212 so that the precertification can be sent within the required timeframe.

General contact information and resource links are listed in the table below:

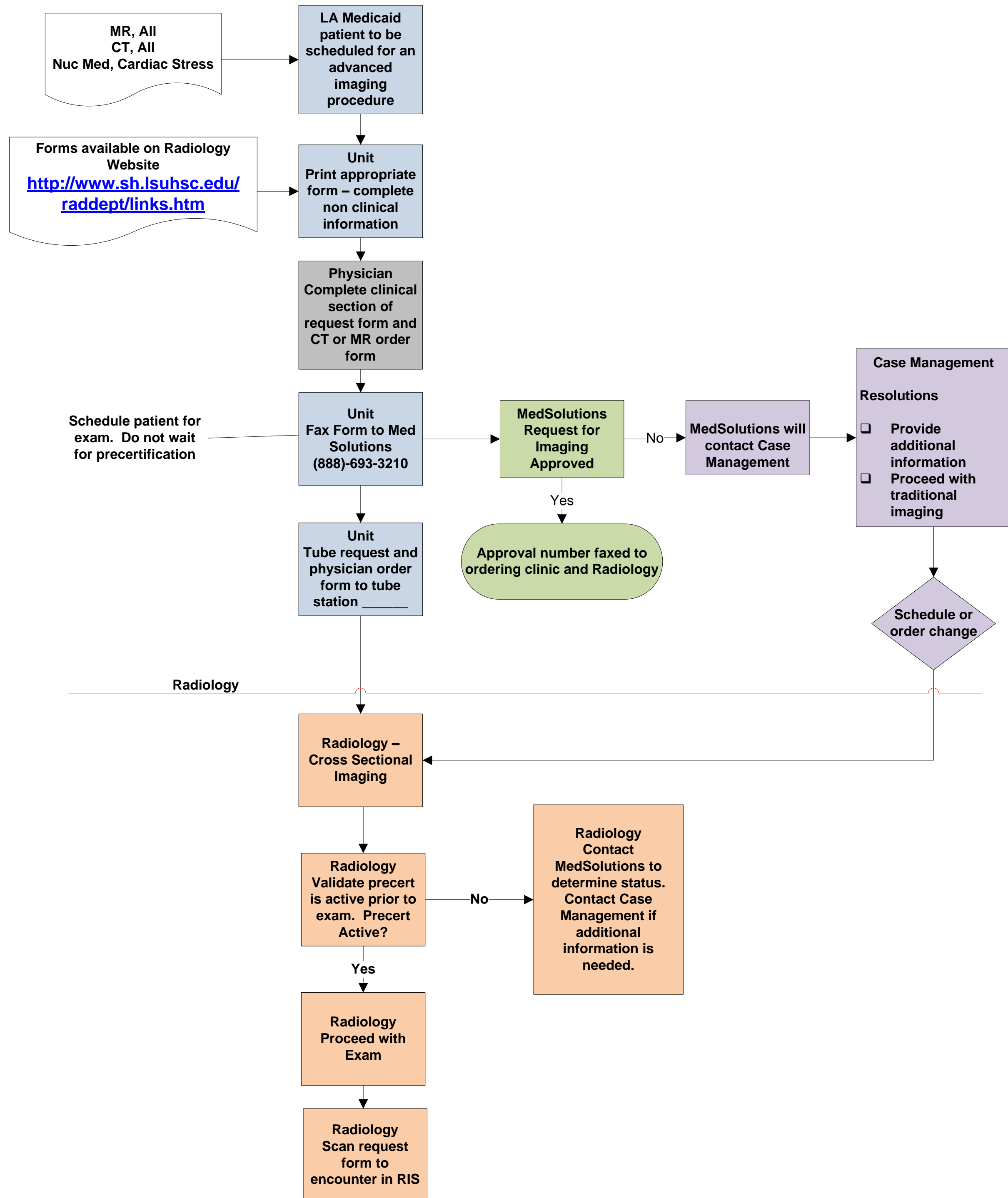
Contact Description	Primary Contact/Number	Secondary Contact(s)/Number
Radiology – Cross Sectional Imaging	Joyce Robert 56212	Deborah Speed 56212 Angela Youngblood 56212
MedSolutions	Routine and Urgent requests 888-693-3211	Precert Fax 888-693-3210
Case Management		

Resource	
MedSolutions Web Portal	https://www.medsolutionsonline.com
Precert Forms	http://www.sh.lsuhsc.edu/raddept/links.htm
ICD9 Information	http://www.sh.lsuhsc.edu/raddept/links.htm

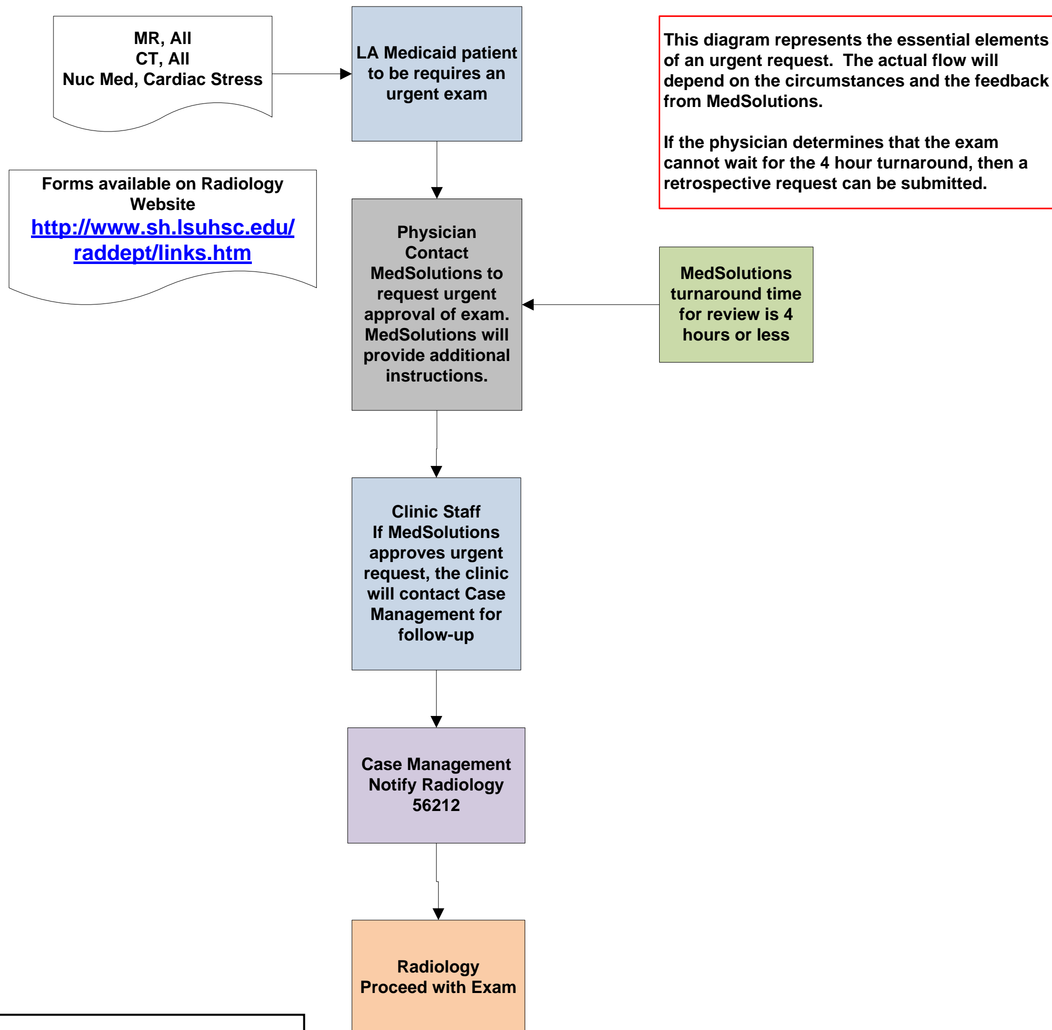
Outpatient Clinic Process



Inpatient Discharge – Patient needs to be scheduled for an outpatient exam



Urgent or Emergent Exam (This does not apply to Emergency Room Patients) Note: If the exam cannot wait for precertification, then the approval form will be submitted for a retrospective review.



For urgent/emergent exams, it is important for case management and radiology to work together to ensure that the exam can be performed and completed within the requested timeframe.

Request Forms:

Precertification forms can be printed or downloaded from the radiology department website. http://www.sh.lsuhsc.edu/raddept/lamedicaid.htm. This link will take you to the following table:

DEPARTMENT	ICD9	EXAM PRE-CERT FORM
CT	codes	ABDOMEN AND PELVIS
CT	codes	ABDOMEN AND PELVIS APPENDICITIS
CT	codes	ABDOMEN AND PELVIS RENAL
CT	codes	CHEST
CT	codes	CHEST, ABDOMEN AND PELVIS
CT	codes	CHEST AND NECK
CT	codes	CTA HEAD AND NECK
CT	codes	CT HEAD
CT	codes	CT MAXILLOFACIAL
CT	codes	CT MAXILLOFACIAL AND NECK
CT	codes	CT NECK
CT	codes	CT SPINE
CT	codes	CT HEAD AND NECK
CT/MRI	codes	CT/MR HEAD AND MR SPINE
	ICD9	
MRI	codes	MR ABDOMEN
MRI	codes	MR ABDOMEN AND PELVIS
MRI	codes	MR HEAD
MRI	codes	MR BREAST

MRI	codes	MR KNEE
MRI	codes	MR LOWER/UPPER EXTREMITY JOINT
MRI	codes	MR MRA HEAD
MRI	codes	MR MRA HEAD AND NECK
MRI/CT	codes	CT/MR HEAD AND MR SPINE
MRI	codes	MR PELVIS
MRI	codes	MR SPINE
	ICD9	
NUCLEAR	codes	CARDIAC STRESS

Request forms are found under the CPT column. The column titled codes provides a link to appropriate ICD9 codes for the exam requested.

LIST OF PROCEDURE CODES REQUIRING PRIOR AUTHORIZATION VIA THE RADIOLOGY UTILIZATION MANAGEMENT (RUM) PROGRAM

Revision Date: January 7, 2010

Code	Description
70336	MRI Temporomandibular Joint (s)
70450	CT Head without contrast
70460	CT Head with contrast
70470	CT Head with & without contrast
70480	CT Orbit, et al without contrast
70481	CT Orbit, et al with contrast
70482	CT Orbit, et al W & W/O
70486	CT Maxillofacial area, (sinus) without contrast
70487	CT Maxillofacial area, (sinus) with contrast
70488	CT Maxillofacial area, (sinus) W & W/O
70490	CT Soft-tissue Neck without contrast
70491	CT Soft-tissue Neck with contrast
70492	CT Soft-tissue Neck with & without contrast W & W/O
70496	CTA HEAD, with contrast, including noncontrast images, if performed, & image post-processing
70498	CTA NECK, with contrast, including noncontrast images, if performed, & image post-processing
70540	MRI Orbit, Face and/or Neck without contrast
70542	MRI Orbit, Face and/or Neck with contrast
70543	MRI Orbit, Face and/or Neck W & W/O
70544	MR Angiography (MRA) Head without contrast
70545	MR Angiography (MRA) Head with contrast
70546	MR Angiography (MRA) Head with and without contrast W & W/O
70547	MR Angiography (MRA) Neck without contrast
70548	MR Angiography (MRA) Neck with contrast
70549	MR Angiography (MRA) Neck with and without contrast W & W/O
70551	MRI Brain (Head) without contrast
70552	MRI Brain (Head) with contrast
70553	MRI Brain (Head) with and without contrast W & W/O
70554	MRI Brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration
70555	MRI, Brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing
71250	CT Chest without contrast
71260	CT Chest with contrast
71270	CT Chest with and without contrast W & W/O
71275	CTA CHEST, (non-coronary), with contrast, including noncontrast images, if performed, & image post-processing
71550	MRI Chest without contrast
71551	MRI Chest with contrast
71552	MRI Chest with and without contrast W & W/O
71555	MR Angiography (MRA) Chest (excluding myocardium)- W or W/O
72125	CT Cervical Spine without contrast
72126	CT Cervical Spine with contrast
72127	CT Cervical Spine with and with out contrast W & W/O
72128	CT Thoracic Spine without contrast
72129	CT Thoracic Spine with contrast
72130	CT Thoracic Spine with and without contrast W & W/O
72131	CT Lumbar Spine without contrast
72132	CT Lumbar Spine with contrast

72133	CT Lumbar Spine with and without out contrast W & W/O
72141	MRI Cervical Spine without contrast
72142	MRI Cervical Spine with contrast
72146	MRI Thoracic Spine without contrast
72147	MRI Thoracic Spine with contrast
72148	MRI Lumbar Spine without contrast
72149	MRI Lumbar Spine with contrast
72156	MRI Cervical Spine with and without contrast W & W/O
72157	MRI Thoracic Spine with and without contrast W & W/O
72158	MRI Lumbar Spine with and without contrast W & W/O
72159	MR Angiography (MRA) Spinal Canal and contents -with or w/o contrast
72191	CTA PELVIS, with contrast, including noncontrast images, if performed, & image post-processing
72192	CT Pelvis without contrast
72193	CT Pelvis with contrast
72194	CT Pelvis with and without contrast W & W/O
72195	MRI Pelvis without contrast
72196	MRI Pelvis with contrast
72197	MRI Pelvis with and without contrast W & W/O
72198	MR Angiography (MRA) Pelvis -with or without contrast
73200	CT Upper Extremity without contrast
73201	CT Upper Extremity with contrast
73202	CT Upper Extremity with and without contrast W & W/O
73206	CTA Upper Extremity, with contrast, including noncontrast images, if performed, & image postprocessing
73218	MRI Upper Extremity-other than joint-without contrast
73219	MRI Upper Extremity-other than joint-with contrast
73220	MRI Upper Extremity-other than joint-W & W/O
73221	MRI Any Joint of Upper Extremity--without contrast
73222	MRI Any Joint of Upper Extremity--with contrast
73223	MRI Any Joint of Upper Extremity—W & W/O
73225	MR Angiography (MRA) Upper Extremity -with or without contrast
73700	CT Lower Extremity without contrast
73701	CT Lower Extremity with contrast
73702	CT Lower Extremity with and without contrast W & W/O
73706	CTA Lower Extremity, with contrast, including noncontrast images, if performed, & image postprocessing
73718	MRI Lower Extremity-other than joint-without contrast
73719	MRI Lower Extremity-other than joint-with contrast
73720	MRI Lower Extremity-other than joint- W & W/O
73721	MRI Any Joint of Lower Extremity--without contrast
73722	MRI Any Joint of Lower Extremity--with contrast
73723	MRI Any Joint of Lower Extremity—W & W/O
73725	MR Angiography (MRA) Lower Extremity-with or without contrast
74150	CT Abdomen without contrast
74160	CT Abdomen with contrast
74170	CT Abdomen with and without contrast W & W/O
74175	CTA ABDOMEN, with contrast, including noncontrast images, if performed, & image postprocessing
74181	MRI Abdomen without contrast
74182	MRI Abdomen with contrast
74183	MRI Abdomen with and without contrast W & W/O
74185	MR Angiography (MRA) Abdomen-with or without contrast
75557	Cardiac MRI for morphology and function without contrast
75559	Cardiac MRI for morphology and function without contrast material; with stress imaging
75561	Cardiac MRI for morphology and function without contrast, followed by contrast W & W/O
75563	Cardiac MRI for morphology and function without contrast, followed by contrast; with stress imaging
75565	Cardiac magnetic resonance imaging for velocity flow mapping (List separately in addition to code for primary procedure)

75635	CTA ABDOMINAL AORTA and bilateral iliofemoral lower extremity runoff, with contrast, including noncontrast images, if performed, and image post-processing
76376	3D Rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality; not requiring image postprocessing on an independent workstation
76377	3D Rendering with interpretation and reporting of CT, MRI, ultrasound, or other tomographic modality; requiring image postprocessing on an independent workstation
76380	CT Limited or Localized follow-up
76497	Unlisted CT procedure (eg, diagnostic, interventional)
76498	Unlisted MR procedure (eg, diagnostic, interventional)
77011	CT Guidance for stereotactic localization
77012	CT Guidance for needle placement (eg, biopsy, aspiration, injection), radiological supervision and interpretation
77013	CT Guidance for, and monitoring of, parenchymal tissue ablation
77021	MR guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation (usually used in conjunction with surgery, non-MSI test for most Clients)
77022	MR guidance for, and monitoring of, parenchymal tissue ablation (usually used in conjunction with surgery, non-MSI test for most Clients)
77058	MRI BREAST, without and/or with contrast UNILATERAL
77059	MRI BREAST, without and/or with contrast BILATERAL
77078	CT BONE MINERAL DENSITY study, 1 or more sites, axial skeleton
77079	CT BONE MINERAL DENSITY study, 1 or more sites, appendicular
77084	MRI Bone Marrow blood supply
78451	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78452	Myocardial perfusion imaging, tomographic (SPECT) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
78466	Myocardial Imaging, infarct avid, planar; qualitative or quantitative
78468	Myocardial Imaging, infarct avid, planar; w/ EF by first pass technique
78469	Myocardial Imaging, infarct avid, planar; tomographic SPECT
78472	Cardiac Blood Pool imaging, gated equilibrium; planar, single study at rest or stress
78473	Cardiac Blood Pool imaging, gated equilibrium; multiple studies, wall motion plus ejection fraction, at rest and stress
78481	Cardiac Blood Pool imaging, (planar), first pass technique; single study, at rest or with stress, wall motion study plus ejection fraction
78483	Cardiac Blood Pool imaging, (planar), first pass technique; multiple studies at rest and with stress, wall motion study plus ejection fraction
78494	Cardiac Blood Pool imaging, gated equilibrium, SPECT
78496	Cardiac Blood Pool imaging, gated equilibrium, RV EF by first pass
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine

END OF LIST

Precertification Forms and ICD9 Codes

PRI-SM

CT Abdomen / Pelvis General Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO	Date of Service:

Clinical Information

ICD-9: | **Please circle all that apply: CPT® Code(s): CT ABD:** 74150 74160 74170 **CT PEL:** 72192 72193 72194 OTHER________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician:
   Date (format mm/dd/yyyy) ____________________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone with office staff ☐ Other

Question			
3. Is abdominal or pelvic pain present?	☐ Yes	☐ No	☐ Don't Know
4. Where is the location of pain? Above umbilicus or below? ☐ Above ☐ Don't Know	☐ Below	☐ Both	☐ Does not have pain
5. Is this for left lower quadrant pain?	☐ Yes	☐ No	☐ Don't Know
6. Has there been abdominal or pelvis surgery within the past year?	☐ Yes	☐ No	☐ Don't Know
7. Is fever present?	☐ Yes	☐ No	☐ Don't Know
8. Is there an elevated white blood cell count?	☐ Yes	☐ No	☐ Don't Know
9. Is this to evaluate a hernia?	☐ Yes	☐ No	☐ Don't Know
10. Are there unclear findings on previous imaging studies?	☐ Yes	☐ No	☐ Don't Know
11. Has there been unexplained or unintentional weight loss?	☐ Yes	☐ No	☐ Don't Know
12. Is there a history of diverticulitis?	☐ Yes	☐ No	☐ Don't Know
13. Has treatment with antibiotics been done in the past week?	☐ Yes	☐ No	☐ Don't Know

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ________________________

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

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PRI-SM

CT Abdomen / Pelvis – Appendicitis Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr ID:	Group #	Health Plan:
	Address:	City:	ST:	Zip
Physician Info	Physician First Name:		Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Facility Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: | **Please circle all that apply: CPT® Code(s): CT ABD:** 74150 74160 74170 **CT PEL:** 72192 72193 72194 **OTHER** ________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician
   Date (format mm/dd/yyyy) ______________________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone call with office staff ☐ Other
3. Is abdominal or pelvic pain present? ☐ Yes ☐ No ☐ Don't Know
4. Is this for right lower quadrant pain? ☐ Yes ☐ No ☐ Don't Know
5. Is fever present? ☐ Yes ☐ No ☐ Don't Know
6. Is there an elevated white blood cell count? ☐ Yes ☐ No ☐ Don't Know
7. Is abdominal guarding or rebound tenderness present? ☐ Yes ☐ No ☐ Don't Know

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ________________________

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

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PRI-SM

CT Abdomen / Pelvis Renal Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr ID:	Group #	Health Plan:
	Address:	City:	ST:	Zip
Physician Info	Physician First Name:		Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Facility Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: | **Please circle all that apply: CPT® Code(s):** **CT ABD:** 74150 74160 74170 **CT PEL:** 72192 72193 72194 OTHER________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician:
   Date (format mm/dd/yyyy) ____________________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone call with office staff ☐ Other
3. Is abdominal or pelvic pain present? ☐ Yes ☐ No ☐ Don't Know
4. Where is the location of pain? Above umbilicus or below? ☐ Above ☐ Below ☐ Both ☐ Does not have pain ☐ Don't Know
5. Is flank or back pain present? ☐ Yes ☐ No ☐ Don't Know
6. Is there blood in the urine? ☐ Yes ☐ No ☐ Don't Know
7. Is this to evaluate kidney stones or recent history of kidney stones? ☐ Yes ☐ No ☐ Don't Know

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

CT Chest Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Information

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST:	Zip

Physician Information

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Information

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: | **Please circle all that apply:** CPT® Code(s): 71250 71260 71270 71275 OTHER

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician
   Date (format mm/dd/yyyy) ____________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone call with office staff ☐ Other

	Question				
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

Add Info

Please check the appropriate box describing you:
☐ Ordering Physician
☐ Facility
☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ________________________________ **Date:** ____________________

Sign Name: ________________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

CT Chest, Abdomen, & Pelvis Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name: | Patient Last Name:
DOB: | Mbr ID: | Group #: | Health Plan:
Address: | City: | ST: | Zip

Physician Info

Physician First Name: | Physician Last Name:
Primary Specialty: | NPI: | Tax ID:
Address: | City: | ST: | Zip:
Phone #: | Fax #: | Contact Email:

Facility Info

Facility Name: | Facility Tax ID:
Address: | City: | ST: | Zip:
Phone #: | Fax #: | ☐ RETRO Date of Service:

Clinical Information

ICD-9: | **Please circle all that apply: CPT® Code(s): CT ABD:** 74150 74160 74170
CT PEL: 72192 72193 72194 OTHER____

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)				Date____	☐ 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

Question				
3. Is abdominal or pelvic pain present?	☐ Yes		☐ No	☐ Don't Know
4. Where is the location of pain? Above umbilicus or below?	☐ Above	☐ Below ☐ Both	☐ No	☐ Don't Know
5. Is this for left lower quadrant pain?	☐ Yes		☐ No	☐ Don't Know
6. Has there been abdominal or pelvis surgery within the past year?	☐ Yes		☐ No	☐ Don't Know
7. Is fever present?	☐ Yes		☐ No	☐ Don't Know
8. Is there an elevated white blood cell count?	☐ Yes		☐ No	☐ Don't Know
9. Is this to evaluate a hernia?	☐ Yes		☐ No	☐ Don't Know
10. Are there unclear findings in previous imaging studies? (CT, MRI, Ultrasound, x-ray)	☐ Yes		☐ No	☐ Don't Know
11. Has there been unexplained or unintentional weight loss?	☐ Yes		☐ No	☐ Don't Know
12. Is there a history of diverticulitis?	☐ Yes		☐ No	☐ Don't Know
13. Has treatment with antibiotics been done in the past week?	☐ Yes		☐ No	☐ Don't Know

CT Chest **Please circle all that apply : CPT® Code(s):** 71250 71260 71270 71275 OTHER____

Question				
14. Is this for cancer diagnosis?		☐ Yes	☐ No	☐ Don't Know
15. Is there evidence of cancer in the chest?		☐ Yes	☐ No	☐ Don't Know
16. Is there a new nodule or mass on chest x-ray or imaging study?		☐ Yes	☐ No	☐ Don't Know
17. Was a chest x-ray done within the last 4 weeks and read by a radiologist?		☐ Yes	☐ No	☐ Don't Know
18. Has a chest CT been done within the past year?		☐ Yes	☐ No	☐ Don't Know
19. Is chest pain present?		☐ Yes	☐ No	☐ Don't Know
20. Has a D-dimer been done?	☐ Normal	☐ Abnormal	☐ Test Not Done	☐ Don't Know

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____________________ **Date:** ____________

Sign Name: ____________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

CT Chest/Neck Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions (888) 693-3210.

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Information				
Patient First Name		Patient Last Name		
DOB:	Mbr ID:	Group #:		Health Plan:
Address:	City:		ST:	Zip

Physician Information				
Physician First Name:		Physician Last Name:		
Primary Specialty	NPI:	Tax ID:		
Address:	City:		ST:	Zip
Phone #:	Fax #:	Contact Email:		

Facility Info				
Facility Name:		Tax ID:		
Address:	City:		ST:	Zip
Phone #:	Fax #:	☐ RETRO Date of Service		

Clinical Information

ICD-9: | **Please circle all that apply:** CPT® Code(s): **CT CHEST:** 71250 71260 71270 71275 **CT NECK:** 70490 70491 70492 OTHER ________

☐ Without Contrast | ☐ With Contrast | ☐ Without and With Contrast

Question							
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date ______	☐ 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 mass?	☐ Yes	☐ No	☐ Don't Know				
13. Is the neck mass painful?	☐ Yes	☐ No	☐ Does Not Apply	☐ Don't Know			
14. Has there been difficulty or pain with swallowing?	☐ Yes	☐ No	☐ 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				

Add Info

Please check the appropriate box describing you:

☐ Ordering Physician
☐ Facility
☐ Other ________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________ **Date:** ______________

Sign Name: ______________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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MRA/CTA Head & Neck Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

Please circle all that apply: CPT® Code(s): **CTA HEAD:** 70496 **CTA NECK:** 70498 **MRA HEAD:** 70544 70545 70546 **MRA NECK:** 70547 70548 70549 OTHER_________

ICD-9:	☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast

Question						
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_________			☐ 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	☐ Don't Know
4. Date of previous head imaging?	Date:			☐ Other	☐ None	☐ Don't Know
5. Has there been recent onset of hemiplegia?				☐ Yes	☐ No	☐ Don't Know
6. Is dementia or Alzheimer's disease suspected?	☐ Dementia	☐ Alzheimers		☐ 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 stroke 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 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

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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MRI and CT Head Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info					
Patient First Name:			Patient Last Name:		
DOB:	Mbr ID:	Group #:	Health Plan:		
Address:	City:		ST:	Zip	

Physician Info				
Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:		Tax ID:	
Address:	City:		ST:	Zip:
Phone #:	Fax #:	Contact Email:		

Facility Info				
Facility Name:		Facility Tax ID:		
Address:	City:		ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:		

Clinical Information

ICD-9:	**Please circle all that apply: CPT® Code(s): MRI:** 70336 70540 70542 70543 70551 70552 70553 **CT:** 70450 70460 70470 70496 Other______	
☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast

Question							
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date______	☐ 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 past three years?	☐ Yes	☐ No	☐ Don't Know				
4. Date of previous head imaging? (format mm/dd/yyyy)	Date______	☐ None	☐ Don't Know				
5. Has there been recent onset of hemiplegia?	☐ Yes	☐ No	☐ Don't Know				
6. Is dementia or Alzheimer's disease suspected?	☐ Dementia	☐ Alzheimers	☐ 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 or 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				

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ______

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________ **Date:** ______________________

Sign Name: ______________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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CT Maxillofacial Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210**.

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr ID:	Group #	Health Plan:
	Address:	City:	ST:	Zip
Physician Info	Physician First Name:		Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Facility Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: | Please circle all that apply: **CPT® Code(s):** 70486 70487 70488 OTHER________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician:
   Date (format mm/dd/yyyy) ________________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone with office staff ☐ Other

Question			
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
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?
    ☐ ENT ☐ Neurologist ☐ Other: ______________
    ☐ Allergist ☐ Neurosurgeon ☐ Don't Know
    ☐ Pulmonologist ☐ No

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other __________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ________________________

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

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PRI-SM

CT Maxillofacial & Neck Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group#:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip
Phone#:	Fax#:	Contact Email:	

Facility Info

Facility Name:		Tax ID:	
Address:	City:	ST:	Zip
Phone#:	Fax#:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: **Please circle all that apply: CPT® Code(s): CT NECK:** 70490 70491 70492
CT Maxillofacial: 70486 70487 70488 OTHER____

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

Question							
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date____	☐ 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 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				
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 (ENT)	☐ 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 mass?	☐ Yes	☐ No	☐ Don't Know				
16. Is the neck mass painful? ☐ Does not apply	☐ Yes	☐ No	☐ Don't Know				
17. Has there been difficulty or pain with swallowing?	☐ Yes	☐ No	☐ Don't Know				
18. Is a thyroid problem suspected?	☐ Yes	☐ No	☐ Don't Know				
19. Has neck ultrasound been:	☐ Done	☐ Planned	☐ Neither	☐ Don't Know			
20. Is neck surgery planned?	☐ Yes	☐ No	☐ Don't Know				

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ________________________________ **Date:** ______________________

Sign Name: ________________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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CT Neck Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: | Please circle all that apply: CPT® Code(s): 70490 70491 70492 OTHER__________

☐ Without Contrast | ☐ With Contrast | ☐ Without and With Contrast

Question					
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date	☐ 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 test to image the spine?		☐ Yes	☐ No	☐ Don't Know	
4. Is cancer suspected?	☐ Suspected, not confirmed	☐ Known History	☐ Not Suspected	☐ Don't Know	
5. Is there a neck mass?		☐ Yes	☐ No	☐ Don't Know	
6. Is the neck mass painful?	☐ Yes	☐ No	☐ Does not apply	☐ Don't Know	
7. Has there been difficulty or pain with swallowing?		☐ Yes	☐ No	☐ Don't Know	
8. Is a thyroid problem suspected?		☐ Yes	☐ No	☐ Don't Know	
9. Has a neck ultrasound been:	☐ Done	☐ Planned	☐ Not Done or Planned	☐ Don't Know	
10. Is neck surgery planned?		☐ Yes	☐ No	☐ Don't Know	

Additional Information

Please check the appropriate box describing you:

☐ Ordering Physician
☐ Facility
☐ Other _______________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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CT Spine Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO	Date of Service:

Clinical Information

ICD-9: | Please circle all that apply: **CPT®** Code(s): **(C-Spine)** 72125 72126 72127 **(T-Spine)** 72128 72129 72130 **(L-Spine)** 72131 72132 72133 OTHER____________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician:
   Date (format mm/dd/yyyy) ____________________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone call with office staff ☐ Other
3. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?
   Date (format mm/dd/yyyy) ____________________ ☐ This is the first visit for this episode
   Free Text:_______________________________ ☐ Don't Know
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 recent head or neck trauma? ☐ Yes ☐ No ☐ Don't Know
7. In the last two months, has there been significant trauma to the spine involving:
   ☐ A motor vehicle accident (MVA) ☐ Any fall landing on the head ☐ No injury or trauma
   ☐ A fall from a height ☐ A head trauma with loss of consciousness ☐ Don't Know
   ☐ Other injury or trauma: ____________________
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

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ________________________

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

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PRI-SM

MRI/CT Head & CT Neck Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions (888) 693-3210.

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info				
Patient First Name:		Patient Last Name:		
DOB:	Mbr number:	Group #:		Health Plan:
Address:	City:		ST:	Zip

Physician Info				
Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:		Tax ID:	
Address:	City:		ST:	Zip:
Phone #:	Fax #:	Contact Email:		

Facility Info				
Facility Name:		Tax ID:		
Address:	City:		ST:	Zip:
Phone #:	Fax #:		☐ RETRO Date of Service:	

Clinical Information

Please circle all that apply: CPT® Code(s): CT NECK: 70490 70491 70492 OTHER_______

ICD-9: ☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_________			☐ 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 test to image the spine (neck bones or spinal cord)?	☐ Yes	☐ No	☐ Don't Know				
4. Is cancer suspected?	☐ Suspected, not confirmed	☐ Known History	☐ Not Suspected	☐ Don't Know			
5. Is there a neck mass?	☐ Yes	☐ No	☐ Don't Know				
6. Is the neck mass painful?	☐ Yes	☐ No	☐ Does Not Apply	☐ Don't Know			
7. Has there been difficulty or pain with swallowing?	☐ Yes	☐ No	☐ Don't Know				
8. Is a thyroid problem suspected?	☐ Yes	☐ No	☐ Don't Know				
9. Has a neck ultrasound been:	☐ Done	☐ Planned	☐ Neither	☐ Don't Know			
10. Is neck surgery planned?	☐ Yes	☐ No	☐ Don't Know				

ICD-9: **Please circle all that apply: CPT® Code(s): MRI HEAD:** 70336 70540 70542 70543 70551 70552 70553 **CT HEAD:** 70450 70460 70470 70496 Other_______

11. Is there previous head imaging for this problem within the past three years?	☐ Yes	☐ No	☐ Don't Know		
12. Date of previous head imaging?	Date_________	☐ Don't Know	☐ Other	☐ None	
13. Has there been recent onset of hemiplegia?	☐ Yes	☐ No	☐ Don't Know		
14. Is dementia or Alzheimer's disease suspected?	☐ Dementia	☐ Alzheimers	☐ Both	☐ Neither	☐ Don't Know
15. Has there been a new onset of epileptic seizure?	☐ Yes	☐ No	☐ Don't Know		
16. Is there a history of migraines?	☐ Yes	☐ No	☐ Don't Know		
17. Has there been persistent unresponsive vertigo despite several days of treatment?	☐ Yes	☐ No	☐ Don't Know		
18. Has a trial of physician-directed treatment been completed?	☐ Yes	☐ No	☐ Don't Know		
19. Has physician-directed treatment of at least 3 weeks failed to help the problem?	☐ Yes	☐ No	☐ Don't Know		
20. When did treatment start?	☐ Less than 1 month ago	☐ More than 1 month ago	☐ No Treatment	☐ Does not apply	☐ Don't Know
21. Can the patient walk normally?	☐ Yes	☐ No	☐ Don't Know		
22. Is there a known brain tumor?	☐ Yes	☐ No	☐ Don't Know		

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ______________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

MRI/CT Head & MRI Spine Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name: | Patient Last Name:
DOB: | Mbr ID: | Group #: | Health Plan:
Address: | City: | ST: | Zip

Physician Info

Physician First Name: | Physician Last Name:
Primary Specialty: | NPI: | Tax ID:
Address: | City: | ST: | Zip:
Phone #: | Fax #: | Contact Email:

Facility Info

Facility Name: | Facility Tax ID:
Address: | City: | ST: | Zip:
Phone #: | Fax #: | ☐ RETRO Date of Service:

Clinical Information

ICD-9: | **Please circle all that apply:** CPT® Code(s): **(C-Spine)** 72141 72142 72156 **(T-Spine)** 72146 72147 72157 **(L-Spine)** 72148 72149 72158 OTHER

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy) | Date ______ | ☐ 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 (format mm/dd/yyyy) | ☐ This is the first visit for this episode | Date ______ | ☐ Don't Know
4. Is there previous imaging for this problem within the past 6 months? | ☐ Yes | ☐ No | ☐ Don't Know
5. Is there a personal history of cancer other than ordinary skin cancer? | ☐ Yes | ☐ No | ☐ Don't Know
6. Has there been failure to improve with physician directed treatment? | ☐ 4 weeks or less | ☐ 6 weeks | ☐ 8 or more wks | ☐ No Treatment | ☐ Don't Know
7. In the last two months, has there been significant trauma to the spine involving:
   ☐ A motor vehicle accident (MVA) ☐ Any fall landing on the head ☐ No injury or trauma
   ☐ A fall from a height ☐ A head trauma with loss of consciousness ☐ Don't Know
   ☐ Other injury or trauma: ____________________
8. Is the imaging request related to back or neck pain? | ☐ Yes | ☐ No | ☐ Don't Know

MRI/CT Head **Please circle all that apply:** CPT® Code(s): **MRI:** 70336 70540 70542 70543 70551 70552 70553 **CT:** 70450 70460 70470 70496 Other

9. Is there previous head imaging for this problem within the past three years? | ☐ Yes | ☐ No | ☐ Don't Know
10. Date of previous head imaging? | Date ______ | ☐ Don't Know | ☐ None
11. Has there been recent onset of hemiplegia? | ☐ Yes | ☐ No | ☐ Don't Know
12. Is dementia or Alzheimer's disease suspected? | ☐ Dementia | ☐ Alzheimers | ☐ Both | ☐ Neither | ☐ Don't Know
13. Has there been a new onset of epileptic seizure? | ☐ Yes | ☐ No | ☐ Don't Know
14. Is there a history of migraines? | ☐ Yes | ☐ No | ☐ Don't Know
15. Has there been persistent unresponsive vertigo despite several days of treatment? | ☐ Yes | ☐ No | ☐ Don't Know
12. Has a trial of physician-directed treatment been completed? | ☐ Yes | ☐ No | ☐ Don't Know
13. Has physician–directed treatment of as least 3 weeks failed to help the problem? | ☐ Yes | ☐ No | ☐ Don't Know
14. When did treatment start? | ☐ Less than 1 month | ☐ More than 1 month | ☐ No Treatment | ☐ Does not apply | ☐ Don't Know
15. Can the patient walk normally? | ☐ Yes | ☐ No | ☐ Don't Know
16. Is there a known brain tumor? | ☐ Yes | ☐ No | ☐ Don't Know

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

MRI Abdomen Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr ID:	Group #	Health Plan:
	Address:	City:	ST:	Zip
Physician Info	Physician First Name:		Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Facility Tax ID:	
	Address:	City:	ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: **Please circle all that apply: CPT® Code(s):** 74181 74182 74183 OTHER__________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician
   Date (format mm/dd/yyyy) ______________ ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with physician ☐ Don't Know
   ☐ Office visit ☐ Email
   ☐ Phone with office staff ☐ Other

Question			
3. Is there a reason to avoid CT contrast?	☐ Yes	☐ No	☐ Don't Know
4. Is a lipoma suspected?	☐ Yes	☐ No	☐ Don't Know
5. Are there unclear findings on a previous ultrasound?	☐ Yes	☐ No	☐ Don't Know
6. Is there a current pregnancy?	☐ Yes	☐ No	☐ Don't Know
7. Is this for right lower quadrant pan with associated fever?	☐ Yes	☐ No	☐ Don't Know
8. Is this to evaluate causes of hematuria?	☐ Yes	☐ No	☐ Don't Know
9. Is pain present?	☐ Yes	☐ No	☐ Don't Know
10. Are there unclear finding on previous CT-Abdomen imaging?	☐ Yes	☐ No	☐ Don't Know
11. Is this for right upper quadrant pain with associated fever?	☐ Yes	☐ No	☐ Don't Know
12. Is jaundice present?	☐ Yes	☐ No	☐ Don't Know
13. Is the AFP elevated?	☐ Yes	☐ No	☐ Don't Know
14. Is the study to evaluate a liver lesion?	☐ Yes	☐ No	☐ Don't Know

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other __________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

MRI Abdomen & Pelvis Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr ID:	Group #:	Health Plan:
	Address:	City:	ST:	Zip
Physician Info	Referring/Requesting Physician First Name:		Referring/Requesting Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Facility Tax ID:	
	Address:	City:	ST:	Zip
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: **Please circle all that apply: CPT® Code(s): MRI Abdomen:** 74181 74182 74183 **MRI Pelvis:** 72195 72196 72197 OTHER______

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

Question			
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date______	☐ 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 a reason to avoid CT contrast (allergy to contrast material or renal failure)?	☐ Yes	☐ No	☐ Don't Know
4. Is a lipoma suspected?	☐ Yes	☐ No	☐ Don't Know
5. Are there unclear findings on previous ultrasound?	☐ Yes	☐ No	☐ Don't Know
6. Is there a current pregnancy?	☐ Yes	☐ No	☐ Don't Know
7. Is this for right lower quadrant pain with associated fever?	☐ Yes	☐ No	☐ Don't Know
8. Is this to evaluate for causes of hematuria?	☐ Yes	☐ No	☐ Don't Know
9. Is pain present?	☐ Yes	☐ No	☐ Don't Know
10. Are there unclear findings in previous CT-Abdomen imaging?	☐ Yes	☐ No	☐ Don't Know
11. Is this for right upper quadrant pain with associated fever?	☐ Yes	☐ No	☐ Don't Know
12. Is jaundice present?	☐ Yes	☐ No	☐ Don't Know
13. Is the AFP elevated?	☐ Yes	☐ No	☐ Don't Know
14. Is the study to evaluate a liver lesion?	☐ Yes	☐ No	☐ Don't Know
15. Are there unclear findings in previous CT-Pelvis imaging?	☐ Yes	☐ No	☐ Don't Know
16. Is this for pre or post surgery evaluation?	☐ Yes	☐ No	☐ Don't Know
17. Is a UAE planned?	☐ Yes	☐ No	☐ Don't Know
18. Has a UAE been completed within the last 6 months?	☐ Yes	☐ No	☐ Don't Know
19. Is abnormal uterine or vaginal bleeding present?	☐ Yes	☐ No	☐ Don't Know
20. Has there been a period of conservative treatment (Birth control pills or Hormones)?	☐ Yes	☐ No	☐ Don't Know

Add Info

Please check the appropriate box describing you ☐ Ordering Physician ☐ Facility ☐ Other __________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

MRI and CT Head Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info					
Patient First Name:			Patient Last Name:		
DOB:	Mbr ID:	Group #:		Health Plan:	
Address:		City:		ST:	Zip

Physician Info					
Physician First Name:			Physician Last Name:		
Primary Specialty:		NPI:		Tax ID:	
Address:		City:		ST:	Zip:
Phone #:	Fax #:		Contact Email:		

Facility Info					
Facility Name:			Facility Tax ID:		
Address:		City:		ST:	Zip:
Phone #:	Fax #:		☐ RETRO Date of Service:		

Clinical Information

ICD-9:

Please circle all that apply: **CPT®** Code(s): **MRI:** 70336 70540 70542 70543 70551 70552 70553 **CT:** 70450 70460 70470 70496 Other________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

Question							
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date________	☐ 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 past three years?	☐ Yes	☐ No	☐ Don't Know				
4. Date of previous head imaging? (format mm/dd/yyyy)	Date________	☐ None	☐ Don't Know				
5. Has there been recent onset of hemiplegia?	☐ Yes	☐ No	☐ Don't Know				
6. Is dementia or Alzheimer's disease suspected?	☐ Dementia	☐ Alzheimers	☐ 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 or 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				

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

Breast MRI Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info					
Patient First Name:			Patient Last Name:		
DOB:	Gender: M / F	Mbr ID:	Group #		Health Plan:
Address:		City:		ST:	Zip

Physician Information				
Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:		Tax ID:	
Address:	City:		ST:	Zip
Phone #:	Fax #:	Contact Email:		

Facility Info				
Facility Name:		Tax ID:		
Address:	City:		ST:	Zip
Phone #:	Fax #:	☐ RETRO Date of Service:		

Clinical Information

ICD-9: | **Please circle all that apply: CPT® Code(s): MRI Breast: 77058 77059**

#	Question						
1.	Date of most recent office visit or other documented contact with physician:	Date ______	☐ Don't Know	☐ None			
2.	Type of most recent contact with physician?	☐ Hospital	☐ Office visit	☐ Phone call with office staff	☐ Phone call with Physician	☐ Email	☐ Other	☐ Don't Know
3.	Is this an annual or screening MRI? (Hint: no breast lesion or problems)	☐ Yes	☐ No	☐ Don't Know			
4.	Is there a history of breast cancer?	☐ Yes	☐ No	☐ Don't Know			
5.	Is there a known breast lesion? (choose all that apply)	☐ Yes, mass on physical exam	☐ Yes, mass on Mammogram	☐ Yes mass on Ultrasound	☐ Yes, mass on previous MRI or CT	☐ No	☐ Don't Know
6.	Date of last imaging study?	Date ________	☐ Performed but date unknown	☐ Unknown if imaging was performed	☐ Previous imaging not done		
7.	Is a breast biopsy planned?	☐ Yes	☐ No	☐ Don't Know			
8.	Is this breast MRI for a MRI guided biopsy?	☐ Yes	☐ No	☐ Don't Know			
9.	Has a breast biopsy been performed within the last 6 months?	☐ Yes	☐ No	☐ Don't Know			
10.	Is there a new diagnosis of breast cancer proven by biopsy?	☐ Yes	☐ No	☐ Don't Know			

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ____________________________

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

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PRI-SM

MRI Knee Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section					
Member Info	Patient First Name:		Patient Last Name:		
	DOB:	Mbr ID:	Group #	Health Plan:	
	Address:	City:		ST:	Zip
Physician Information	Physician First Name:		Physician Last Name:		
	Primary Specialty:	NPI:		Tax ID:	
	Address:	City:		ST:	Zip:
	Phone #:	Fax #:	Contact Email:		
Facility Info	Facility Name:		Facility Tax ID:		
	Address:	City:		ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:		
Clinical Information	ICD-9:	**Please circle all that apply: CPT®** Code(s): 73721 73722 73723 OTHER______________			
	☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast		
	1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_________	☐ 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 (knee pain, etc.)? Date (format mm/dd/yyyy)	☐ This is the first visit for this episode	Date ________________ Free Text:_______________	☐ Don't Know	
	4. Has a specialist evaluation been completed?	☐ Orthopedist	☐ Sports Medicine	☐ Podiatrist	☐ No ☐ Don't Know
	5. Has there been a recent injury?	☐ Within past 2 Months	☐ More than 2 Months	☐ No	☐ Don't Know
	6. Has an X-ray been done?	☐ Yes	☐ No	☐ Don't Know	
	7. Is there a personal history of cancer other than ordinary skin cancer?	☐ Yes	☐ No	☐ Don't Know	
	8. Is this study to evaluate arthritis?	☐ Yes	☐ No	☐ Don't Know	
	9. Are the knee ligaments stable upon examination?	☐ Yes	☐ No	☐ Don't Know	
	10. Is there a positive McMurray test?	☐ Yes	☐ No	☐ Don't Know	
	11. Does the knee have full extension upon examination?	☐ Yes	☐ No	☐ Don't Know	
	12. Has there been a period of conservative treatment?	☐ 3 weeks or less ☐ 4 weeks ☐ 6 weeks	☐ 8 weeks or more	☐ None	☐ Don't Know
Add Info	Please check the appropriate box describing you:	☐ Ordering Physician ☐ Facility ☐ Other ____________			
Signature	**Please Sign and Date Below:** Responsible Contact:				
	Print Name: ____	**Date:** ________________________			
	Sign Name: ____	☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**			

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PRI-SM

MRI LE & UE Joint Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section					
Member Info	Patient First Name:		Patient Last Name:		
	DOB:	Mbr ID:	Group #	Health Plan:	
	Address:	City:		ST:	Zip
Physician Information	Physician First Name:		Physician Last Name:		
	Primary Specialty:	NPI:		Tax ID:	
	Address:	City:		ST:	Zip:
	Phone #:	Fax #:	Contact Email:		
Facility Info	Facility Name:		Facility Tax ID:		
	Address:	City:		ST:	Zip:
	Phone #:	Fax #:	☐ RETRO Date of Service:		
Clinical Information	ICD-9:	**Please circle all that apply: CPT® Code(s): MRI UE JOINT:** 73221 73222 73223 **MRI LE JOINT:** 73721 73722 73723 OTHER______			
	☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast		
	1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)		Date________	☐ 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 (shoulder pain, knee pain, etc.)? Date (format mm/dd/yyyy)	Date____________	☐ This is the first visit for this episode ☐ Don't Know		Free text: ____________ ____________
	4. Has a specialist evaluation been completed?		☐ Yes	☐ No	☐ Don't Know
	5. Has there been a recent injury?		☐ Yes	☐ No	☐ Don't Know
	6. Has an X-Ray been done?		☐ Yes	☐ No	☐ Don't Know
	7. Is there a PERSONAL history of cancer other than ordinary skin cancer?		☐ Yes	☐ No	☐ Don't Know
	8. Is this study to evaluate arthritis?		☐ Yes	☐ No	☐ Don't Know
	9. What is the range of motion?	☐ Full Motion	☐ Limited/ Painful		☐ Don't Know
	10. Has there been a period of conservative treatment?	☐ 3 weeks or less ☐ 4 weeks	☐ 6 weeks ☐ 8 weeks or more	☐ No treatment	☐ Don't Know
Add Info	Please check the appropriate box describing you:	☐ Ordering Physician ☐ Facility ☐ Other ____________			
Signature	**Please Sign and Date Below:** Responsible Contact:				
	Print Name: ____________________________		**Date:** ____________________		
	Sign Name: ____________________________		☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**		

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PRI-SM

MRI/MRA Head Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions at (888) 693-3210.

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Information

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Information

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

Please circle all that apply: CPT® Code(s): MRI HEAD: 70336 70540 70542 70543 70551 70552 70553
MRA HEAD: 70544 70545 70546 70547 70548 70549 OTHER________

ICD-9:	☐ Without Contrast		☐ With Contrast		☐ Without and With Contrast		
1. Date of most recent office visit or other documented contact with Physician: Date format (mm/dd/yyyy)	Date				☐ 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	☐ Don't Know
4. Date of previous head imaging? Date format (mm/dd/yyyy)	Date			☐ Don't Know		☐ Other	☐ None
5. Has there recent onset of hemiplegia?			☐ Yes		☐ No		☐ Don't Know
6. Is dementia or Alzheimer's disease suspected?	☐ Dementia		☐ Alzheimers	☐ 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 stroke 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 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

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician
☐ Facility
☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ____________________________

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

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PRI-SM

MRA/CTA Head & Neck Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

Please circle all that apply: **CPT**® Code(s): **CTA HEAD:** 70496 **CTA NECK:** 70498 **MRA HEAD:** 70544 70545 70546 **MRA NECK:** 70547 70548 70549 OTHER ___________

ICD-9: ☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

Question				
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date__________	☐ 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	☐ Don't Know	
4. Date of previous head imaging? Date: __________	☐ Other	☐ None	☐ Don't Know	
5. Has there been recent onset of hemiplegia?	☐ Yes	☐ No	☐ Don't Know	
6. Is dementia or Alzheimer's disease suspected? ☐ Dementia ☐ Alzheimers	☐ 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 stroke 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 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	

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ______________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ___________________________

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

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PRI-SM

MRI/CT Head & MRI Spine Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #:	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO	Date of Service:

Clinical Information

ICD-9: **Please circle all that apply:** CPT® Code(s): **(C-Spine)** 72141 72142 72156 **(T-Spine)** 72146 72147 72157 **(L-Spine)** 72148 72149 72158 OTHER

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy) — Date ____ ☐ 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 (format mm/dd/yyyy) — ☐ This is the first visit for this episode | Date ____ | ☐ Don't Know
4. Is there previous imaging for this problem within the past 6 months? ☐ Yes ☐ No ☐ Don't Know
5. Is there a personal history of cancer other than ordinary skin cancer? ☐ Yes ☐ No ☐ Don't Know
6. Has there been failure to improve with physician directed treatment? ☐ 4 weeks or less ☐ 6 weeks ☐ 8 or more wks ☐ No Treatment ☐ Don't Know
7. In the last two months, has there been significant trauma to the spine involving:
   - ☐ A motor vehicle accident (MVA) ☐ Any fall landing on the head ☐ No injury or trauma
   - ☐ A fall from a height ☐ A head trauma with loss of consciousness ☐ Don't Know
   - ☐ Other injury or trauma: ____________________
8. Is the imaging request related to back or neck pain? ☐ Yes ☐ No ☐ Don't Know

MRI/CT Head **Please circle all that apply:** CPT® Code(s): **MRI:** 70336 70540 70542 70543 70551 70552 70553 **CT:** 70450 70460 70470 70496 Other

9. Is there previous head imaging for this problem within the past three years? ☐ Yes ☐ No ☐ Don't Know
10. Date of previous head imaging? Date ____ ☐ Don't Know ☐ None
11. Has there been recent onset of hemiplegia? ☐ Yes ☐ No ☐ Don't Know
12. Is dementia or Alzheimer's disease suspected? ☐ Dementia ☐ Alzheimers ☐ Both ☐ Neither ☐ Don't Know
13. Has there been a new onset of epileptic seizure? ☐ Yes ☐ No ☐ Don't Know
14. Is there a history of migraines? ☐ Yes ☐ No ☐ Don't Know
15. Has there been persistent unresponsive vertigo despite several days of treatment? ☐ Yes ☐ No ☐ Don't Know
12. Has a trial of physician-directed treatment been completed? ☐ Yes ☐ No ☐ Don't Know
13. Has physician–directed treatment of as least 3 weeks failed to help the problem? ☐ Yes ☐ No ☐ Don't Know
14. When did treatment start? ☐ Less than 1 month ☐ More than 1 month ☐ No Treatment ☐ Does not apply ☐ Don't Know
15. Can the patient walk normally? ☐ Yes ☐ No ☐ Don't Know
16. Is there a known brain tumor? ☐ Yes ☐ No ☐ Don't Know

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**

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PRI-SM

MRI Pelvis Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions (888) 693-3210.

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Section				
Member Info	Patient First Name:		Patient Last Name:	
	DOB:	Mbr IDr:	Group #:	Health Plan:
	Address:	City:	ST:	Zip
Physician Information	Physician First Name:		Physician Last Name:	
	Primary Specialty:	NPI:	Tax ID:	
	Address:	City:	ST:	Zip
	Phone #:	Fax #:	Contact Email:	
Facility Info	Facility Name:		Tax ID:	
	Address:	City:	ST:	Zip
	Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information				
ICD-9:	**Please circle all that apply: CPT® Code(s):** 72195 72196 72197 OTHER___________			
☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast		
1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_________	☐ 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 a reason to avoid CT contrast?	☐ Yes	☐ No	☐ Don't Know	
4. Is there a current pregnancy?	☐ Yes	☐ No	☐ Don't Know	
5. Is this for right lower quadrant pain with associated fever?	☐ Yes	☐ No	☐ Don't Know	
6. Is this to evaluate causes of hematuria?	☐ Yes	☐ No	☐ Don't Know	
7. Is pain present?	☐ Yes	☐ No	☐ Don't Know	
8. Are there unclear finding in previous CT-Pelvis imaging?	☐ Yes	☐ No	☐ Don't Know	
9. Is this for pre or post surgery evaluation?	☐ Yes	☐ No	☐ Don't Know	
10. Is a UAE planned?	☐ Yes	☐ No	☐ Don't Know	
11. Has a UAE been completed within the last 6 months?	☐ Yes	☐ No	☐ Don't Know	
12. Is abnormal uterine or vaginal bleeding present?	☐ Yes	☐ No	☐ Don't Know	
13. Has there been a period of conservative treatment?	☐ Yes	☐ No	☐ Don't Know	

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ____ **Date:** ____________________________

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

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PRI-SM

MRI Spine Imaging Request

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URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST:	Zip

Physician Info

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO	Date of Service:

Clinical Information

ICD-9:

Please circle all that apply: CPT® Code(s): **(C-Spine)** 72141 72142 72156 **(T-Spine)** 72146 72147 72157 **(L-Spine)** 72148 72149 72158 OTHER___________

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy) — Date________ ☐ 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 (format mm/dd/yyyy) — ☐ This is the first visit for this episode ☐ Don't Know — Date_____________ — Free Text:
4. Is there previous imaging for this problem within the past six months? ☐ Yes ☐ No ☐ Don't Know
5. Is there a personal history of cancer other than ordinary skin cancer? ☐ Yes ☐ No ☐ Don't Know
6. Has there been failure to improve with physician directed treatment? ☐ 4 weeks or less ☐ 6 weeks ☐ 8 weeks or more ☐ No Treatment ☐ Don't Know
7. In the last two months, has there been significant trauma to the spine involving:
   - ☐ A motor vehicle accident (MVA)
   - ☐ Any fall landing on the head
   - ☐ No injury or trauma
   - ☐ A fall from a height
   - ☐ A head trauma with loss of consciousness
   - ☐ Don't Know
   - ☐ Other injury or trauma: ___________________
8. Is the imaging request related to back or neck pain? ☐ Yes ☐ No ☐ Don't Know

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ____________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: ______________________________ **Date:** ____________________

Sign Name: ______________________________ ☐ **MD** ☐ **RN** ☐ **LPN** ☐**PA** ☐ **NP** ☐ **OTHER**

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Cardiac Nuclear Imaging Request

PRI-SM

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MedSolutions reserves the right to request detailed information for the patient.
Fax requests (non urgent requests only) to MedSolutions (888) 693-3210.
URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Information

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST	Zip:

Physician Information

Physician First Name:		Physician Last Name:	
Primary Specialty:	NPI:	Tax ID:	
Address:	City:	ST	Zip:
Phone #:	Fax #:	Contact Email:	

Facility Information

Facility Name:		Facility Tax ID:	
Address:	City:	ST	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service	

Clinical Information

ICD-9: **Please circle all that apply:** CPT® Code(s): 78465 78478 78480 78460 78461 78464 78466 78468 78469 78472 78473 78481 78483 78494 78496 78499 OTHER

1. Date of most recent office visit or other documented contact with physician? Date (format mm/dd/yyyy) ______________
   ☐ 30 days or less ☐ More than 30 days ☐ None ☐ Don't Know
2. Type of most recent documented contact with physician?
   ☐ Hospital ☐ Phone call with office staff ☐ Email ☐ Don't Know
   ☐ Office visit ☐ Phone call with physician ☐ Other
3. Are symptoms present? ☐ Yes ☐ No ☐ Don't Know
4. If symptoms are present, are the symptoms worsening? ☐ Yes ☐ No ☐ Don't Know ☐ Does not apply
5. Has an EKG been performed? ☐ Yes ☐ No ☐ Don't Know
6. What was the date of the most recent EKG? Date (format mm/dd/yyyy) ☐ Don't Know ☐ No EKG performed
7. Is the EKG Normal or Abnormal?
   ☐ Normal ☐ Don't Know ☐ Abnormal ☐ No EKG Performed
8. Can exercise on a treadmill be performed? ☐ Yes ☐ No ☐ Don't Know
9. What is the resting heart rate? Beats/Min _____ (Please enter a number between 30 and 150) ☐ Don't Know
10. What was the most recent blood pressure? Systolic________ (Please enter a number between 70 and 240) ☐ Don't Know
    Diastolic (Please enter a number between 0 and 130)
11. Is there a history of hypertension? ☐ Yes ☐ No ☐ Don't Know
12. Is there a lifetime history of smoking of 5 years or more? ☐ Yes ☐ No ☐ Don't Know
13. Is diabetes present? ☐ Yes ☐ No ☐ Don't Know
14. Is there a history of high cholesterol? ☐ Yes ☐ No ☐ Don't Know
15. Is there a history of peripheral vascular disease? ☐ Yes ☐ No ☐ Don't Know
16. Has there been any heart testing (other than EKG) within the past two years? ☐ Yes ☐ No ☐ Don't Know
17. Is there a history of bypass surgery? ☐ Yes ☐ No ☐ Don't Know
18. Enter date of most recent bypass surgery: Date (format mm/dd/yyyy) Date______________
    ☐ Five years ago or less ☐ More than 5 years ago ☐ Don't Know ☐ No bypass surgery done
19. What other heart procedures have been done? ☐ Angioplasty (PCI), PTCA, stent ☐ Cardiac catheter ☐ Ablation
    ☐ Pacemaker ☐Other:_______________ ☐None ☐Don't Know
    Other heart procedure (Free Text): ☐ None ☐ Don't Know
20. Enter date of most recent Angioplasty (PTCA, PCI) and/or stent procedure: Date (format mm/dd/yyyy) Date________________
    ☐ Five years ago or less ☐ More than 5 years ago ☐ Don't Know ☐ No procedure done
21. Weight as measured in Pounds (lbs): Weight (lbs) (Please enter a number between 1 and 750) ☐ Don't Know
22. Height as measured in Feet (ft) and Inches (in) : Height (ft) _______ (Please enter a number between 1 and 8) ☐ Don't Know
    Height (in) (Please enter a number between 0 and 96)

Add Info

Please check the appropriate box describing you: ☐ Ordering Physician ☐ Facility ☐ Other ___________

Signature

Please Sign and Date Below: Responsible Contact:

Print Name:_______________________________________ Date:__________________________________

Sign Name: ☐ MD ☐ RN ☐ LPN ☐ PA ☐ NP ☐ OTHER

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