Louisiana Medicaid Radiology Precertification Reference

LSUHSC Shreveport RUMS Reference

Introduction:

Effective February 15, 2010 Louisiana Medicaid is requiring precertification for advanced imaging of outpatients. For the purpose of precertification advanced imaging is defined as:

- 🛛 СТ
- □ 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

UNISVS



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

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

management of medical imaging services.

Note:

Information regarding the RUM program can be found by following the link <u>http://www.medsolutions.com/implementation/ladhh/index.html</u> to access the program announcement letter, quick reference guide, and a schedule for webbased 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.

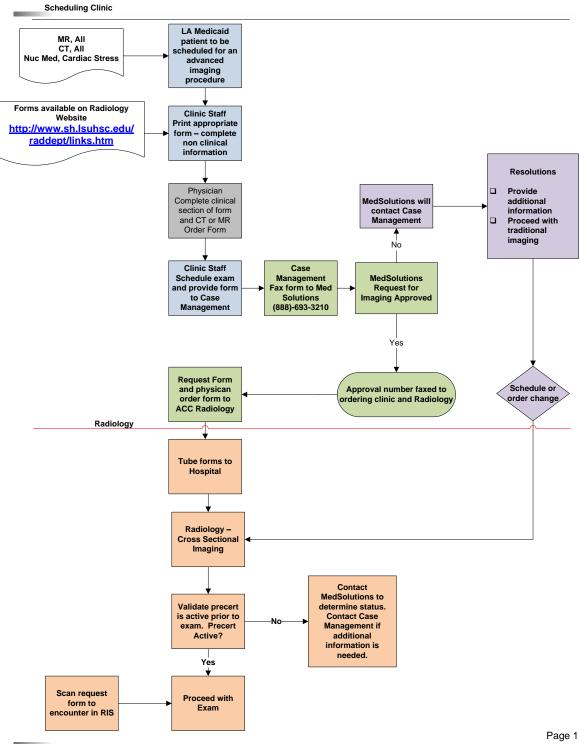
Precertification is valid for 60 days. If the exam is to be scheduled beyond 60 days, please contact Radiology at 56212 so that the precertification can be sent within the required timeframe.

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

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

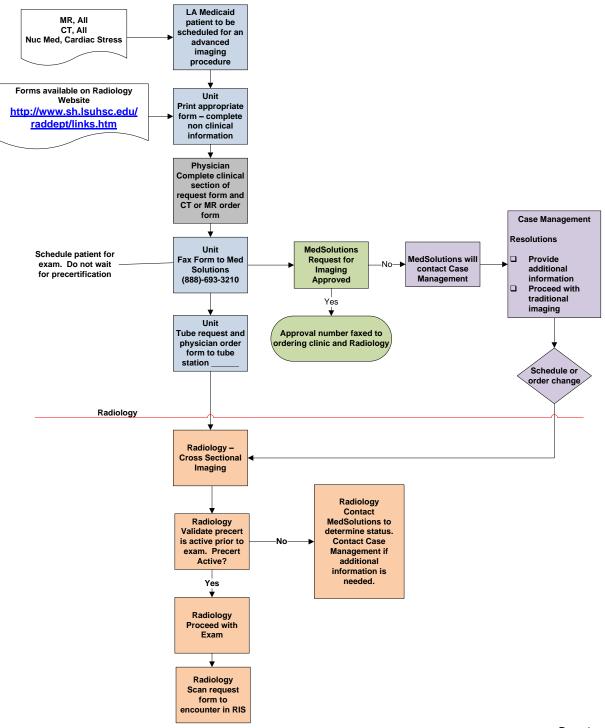
Resource	
MedSolutions Web Portal	https://www.medsolutionsonline.com
Precert Forms	http://www.sh.lsuhsc.edu/raddept/links.htm
ICD9 Information	http://www.sh.lsuhsc.edu/raddept/links.htm

Outpatient Clinic Process



Medicaid Precertification – Outpatient Clinics (Routine, Non Urgent or Emergent

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

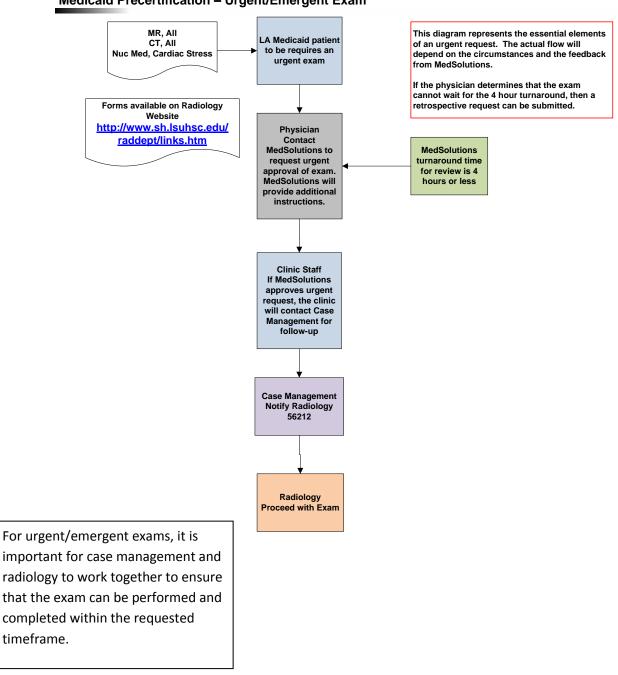


Medicaid Precertification - Inpatient, Exam Scheduled at Discharge

Page 1

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



LSUHSC Shreveport RUMS Reference

Request Forms:

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

DEPARTMENT	ICD9	EXAM PRE-CERT FORM
СТ	codes	ABDOMEN AND PELVIS
СТ	codes	ABDOMEN AND PELVIS APPENDICITIS
СТ	codes	ABDOMEN AND PELVIS RENAL
СТ	codes	CHEST
СТ	codes	CHEST, ABDOMEN AND PELVIS
СТ	codes	CHEST AND NECK
СТ	codes	CTA HEAD AND NECK
СТ	<u>codes</u>	CT HEAD
СТ	codes	CT MAXILLOFACIAL
СТ	codes	CT MAXILLOFACIAL AND NECK
СТ	codes	CT NECK
СТ	codes	CT SPINE
СТ	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	<u>codes</u>	MR KNEE
MRI	<u>codes</u>	MR LOWER/UPPER EXTREMITY JOINT
MRI	<u>codes</u>	MR MRA HEAD
MRI	<u>codes</u>	MR MRA HEAD AND NECK
MRI/CT	<u>codes</u>	CT/MR HEAD AND MR SPINE
MRI	<u>codes</u>	MR PELVIS
MRI	<u>codes</u>	MR SPINE
	ICD9	
NUCLEAR	<u>codes</u>	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
	MRI Temporomandibular Joint (s)
	CT Head without contrast
	CT Head with contrast
	CT Head with & without contrast
	CT Orbit, et al without contrast
	CT Orbit, et al with contrast
	CT Orbit, et al W & W/O
	CT Maxillofacial area, (sinus) without contrast
	CT Maxillofacial area, (sinus) with contrast
70407	CT Maxillofacial area, (sinus) W & W/O
	CT Soft-tissue Neck without contrast
	CT Soft-tissue Neck with contrast
	CT Soft-tissue Neck with & without contrast W & W/O
	CTA HEAD, with contrast, including noncontrast images, if performed, & image post-processing
	CTA NECK, with contrast, including noncontrast images, if performed, & image post-processing
	MRI Orbit, Face and/or Neck without contrast
	MRI Orbit, Face and/or Neck with contrast
	MRI Orbit, Face and/or Neck W & W/O
	MR Angiography (MRA) Head without contrast
	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
	MR Angiography (MRA) Neck with contrast
	MR Angiography (MRA) Neck with and without contrast W & W/O
	MRI Brain (Head) without contrast
	MRI Brain (Head) with contrast
	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
71050	testing
	CT Chest without contrast
	CT Chest with contrast
	CT Chest with and without contrast W & W/O
/12/5	CTA CHEST, (non-coronary), with contrast, including noncontrast images, if performed, & image post- processing
71550	MRI Chest without contrast
	MRI Chest with contrast
	MRI Chest with and without contrast W & W/O
	MR Angiography (MRA) Chest (excluding myocardium)- W or W/O
71555	CT Cervical Spine without contrast
	CT Cervical Spine with contrast
72126	CT Cervical Spine with and with out contrast W & W/O
	CT Thoracic Spine without contrast
	CT Thoracic Spine with contrast
	CT Thoracic Spine with and without contrast W & W/O
	CT Lumbar Spine without contrast
/2132	CT Lumbar Spine with contrast

	CT Lumbar Spine with and without out contrast W & W/O
	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
	MR Angiography (MRA) Spinal Canal and contents -with or w/o contrast
	CTA PELVIS, with contrast, including noncontrast images, if performed, & image post-processing
	CT Pelvis without contrast
	CT Pelvis with contrast
	CT Pelvis with and without contrast W & W/O
	MRI Pelvis without contrast
	MRI Pelvis with contrast
	MRI Pelvis with contrast MRI Pelvis with and without contrast W & W/O
	MR Angiography (MRA) Pelvis -with or without contrast
	CT Upper Extremity without contrast
	CT Upper Extremity with contrast
	CT Upper Extremity with and without contrast W & W/O
	CTA Upper Extremity, with contrast, including noncontrast images, if performed, & image postprocessing
73218	MRI Upper Extremity-other than joint-without contrast
	MRI Upper Extremity-other than joint-with contrast
73220	
73221	MRI Any Joint of Upper Extremitywithout contrast
73222	······································
73223	the second
73225	
	CT Lower Extremity without contrast
	CT Lower Extremity with contrast
	CT Lower Extremity with and without contrast W & W/O
73706	
	MRI Lower Extremity-other than joint-without contrast
	MRI Lower Extremity-other than joint-with contrast
73720	
	MRI Any Joint of Lower Extremitywithout contrast
73722	
73723	
	MR Angiography (MRA) Lower Extremity-with or without contrast
	CT Abdomen without contrast
	CT Abdomen with contrast
	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	
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.

	Patient First Name:	Patient Last Name:									
Member Info	DOB: Mbr ID:	p#:		Health	Health Plan:						
Mer Info	Address:	City:		-			ST:		Zip		
	Physician First Name:				Physician	Last Nar	ne:	-			
s	Primary Specialty:		NPI:					Tax ID	:		
Physician Info	Address:		City:					ST:		Zip:	
£ ₹	Phone #:	Fax #:				Contac	t Email:				
	Facility Name:				Facility Ta:	x ID:					
Allin o	Address:		City:					ST:		Zip:	
R P	Phone #:	Fax #:				R	ETRO I	Date of Se	rvice:		
	ICD-9: Please circle all t	hat apply: C	PT [®] Cod	le(s): (CT ABD: 74	150 741	60 7417	0 CT PEL	: 7219	2 72193 72194	
	OTHER										
	Without Contrast		With Co			ician:		lithout and	With (Contrast	
joj	Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy) None Don't Know										
meti	Type of most recent documented contact with physician? Hospital Phone call with physician Don't Know										
Clinical Information	Office visit	Email	I with phy	ysiciar		Know					
8		Other									
-UI	Is abdominal or pelvic pain pr					_		No No	_	Don't Know	
	4. Where is the location of pain?	Above umb	licus or t	below	P Abov						
	Is this for left lower quadrant processing to the second second						Yes	No		Don't Know	
	Has there been abdominal or	pelvis surger	y within t	the par	st year?		Yes	No		Don't Know	
	Is fever present?						1.22	No No		Don't Know	
	 Is there an elevated white blo Is this to evaluate a hernia? 	oa cell count	<i>!</i>			<u> </u>	Yes	□ No □ No		Don't Know Don't Know	
	10. Are there unclear findings on	provious imp	aina ctur	liar2		 	Yes			Don't Know	
	11. Has there been unexplained				,	<u> </u>				Don't Know	
	12. Is there a history of diverticuli		ar neign				Yes	No		Don't Know	
	13. Has treatment with antibiotics		n the pas	st weel	k?		Yes	No		Don't Know	
	Please check the appropriate box de				dering Physic	cian		_			
Add Info				Fac							
	Diseas Cine and Data Dalarm D				ler						
2	Please Sign and Date Below: R	esponsible C	ontact:								
atur	Print Name:					Da	te:				
Signature	Sign Name:					□ MD			PA 🗌		

IMPORTANT WARNING – This information is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this fax by error, please notify the phone number above immediately and destroy the fax.

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MEDSOLUTIONS

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.

	Patient First Name:						Patient Last Name:							
đe -	DOB: Mbr ID:					Group #					Healt	th Plan:		
Member Info	Address:				City:						ST:		Zip	
	Physician Fi	irst Name:					Physician l	Last N	ame:					
s	Primary Spe	ecialty:			NPI:						Tax I	D:		
sician	Address:				City:								Zip:	
μ	Phone #:			Fax #:				Cont	act Email	:				
	Facility Nam	ie:					Facility Tax	x ID:						
ility	Address:				City:						ST:		Zip:	
Fac	Phone #:			Fax #:	•				RETRO	Da	te of S	Service:	•	
	ICD-9:	Please circle OTHER	e all that a	apply: CPT®C	ode(s):	CT A	BD: 74150	74160	74170	СТ	PEL:	72192 7	2193 72194	
		Contrast		With Co					Without a	nd W	Vith Co	ontrast		
				visit or other o	locume	ented	contact wit		sician None			Don't K		
	Date (format mm/dd/yyyy) 2. Type of most recent documented contact with physician?								None			DONTR	now	
S	Hospital Phone call with physician Don't Know													
nati	Office visit Email Phone call with office staff Other													
lforn		dominal or p			iner				Yes		No		Don't Know	
a L		-		-										
Clinical Information	4. Isthi	s for right lov	ver quad	rant pain?				l	Yes		No		Don't Know	
Ĩ	5. Is fever present?							[Yes		No		Don't Know	
	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 On't Know													
_	Please che	Please check the appropriate box describing you:												
Add Info	Frease check the appropriate box describing you. Graving Physician Facility Other													
2	Please Sigr	n and Date Be	elow: F	Responsible Co	ntact:									
Signature	Print Name	:						0)ate:					
Sign	Sign Name:										.PN			
	-							_	_		_		—	



PRI-SM CT Abdomen / Pelvis Renal 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.

	Patient First Name:							Patient Last Name:					
Aember No	DOB: Mbr ID: Grou						p#		Health	Health Plan:			
hen	Address: City:						ST: 2					Zip	
	Physician First	Name:					Physician	i Last N	lame:				
c	Primary Specia	alty:			NPI:					Tax ID	:		
sician	Address:				City:					ST:		Zip:	
ĘŢ	Phone #:			Fax #:				Con	tact Email:				
	Facility Name:						Facility Ta	ax ID:					
lity	Address:				City:					ST:		Zip:	
Fac	Phone #:		Fa	3X #:	-				RETRO	Date of Se	rvice:		
	ICD-9:	Please ci	rcle all that	t apply: CP	T [®] Code	(s):	CT ABD): 741 721) 74170 ER	CT PE	L: 72192	72193
	Without Cor	ntrast		U With	Contras	st				and With C	Contrast	t	
	Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)												
_	Type of most recent documented contact with physician?												
Clinical Information	Hospital Phone call with physi Office visit Phone call with office staff Other							Don't K	(now				
cal In	3. Is abdominal or pelvic pain present?								Yes	No		Don't Know	
Clini	4. Where is the location of pain? Above umbilicus or below? Above Below Both Does not have pain Don't Know									ive pain			
	5. Is flank (or back pai	n present?						Yes	No No		Don't Know	
	6. Is there	blood in the	e urine?						Yes	No		Don't Know	
	7. Is this to) evaluate k	idney stone	s or recent h	istory of	f kidne	y stones?		Yes	□ No		Don't Know	
Add Info	Please check the appropriate box describing you: Ordering Ph Facility Other												
	Please Sign a	nd Date Be	elow: Re	sponsible Co	ontact:								
Signature	Print Name: _							I	Date:				-
Sig	Sign Name: _												THER



CT Chest 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.

No.	Patient First Name:						Patient Last Name:					
Member Information	DOB: Mbr ID: Grou					p #			Health Plan:			
Men Info	Address:			City:					ST:	Zip		
	Physician First Name:					Physiciar	n Last N	ame:				
s S	Primary Specialty:			NPI:					Tax ID:			
hysici forma	Address:			Ĉity:			act Email:	ST:	Zip:			
22	Phone #:		Fax #:									
c	Facility Name:					Facility T	ax ID:					
lity metio	Address:			City:					ST:	Zip:		
Faci	Phone #:	Fax						RETRO D				
	ICD-9:	OT	HER		pply:			71250 71260		75		
	Without Contrast	-	With Cont					and With Cont	trast			
	Date of most recent office visit or other documented contact with physician Date (format mm/dd/yyyy) None Don't Know											
ion	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											
Clinical Information	Is this for cancer diag	nosis?				□ '	Yes	No No	Don't Know			
ju ja	Is there evidence of e						Yes No Don't K					
Clinic	Is there a new nodule							□ No	Don't Know			
	Was a chest x-ray do a radiologist?				ead b	· -	y Yes No Don't			lon't Know		
	Has a chest CT beer		n the past ye	ar?				□ No		lon't Know		
	Is chest pain present	12					Yes	No		lon't Know		
	9. Has a D-dimer been	done?			lorma	al 🗆 /	Abnorma	al 🗌 Test No	t Done 🔲 🛙	lon't Know		
	Please check the a	appropriate b	box describir	ng you:								
Add Info						Ordering F Facility Other						
	Please Sign and Date Belo	ow: Resp	onsible Con	tact:								
Signature	Print Name:						D	ate:				
Sig	Sign Name:											

MEDISOLUTIONS

CT Chest, Abdomen, & 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.

	Patient First Nan	ne:					Patient I	.ast N	lame:					
Membe r Info	DOB:		Mbr ID:			Grou	p#:				Health			
N.	Address:				City:						ST:		Zip	
e i	Physician First N						Physicia	n Las	st Nam	e:				
hysician No	Primary Specialt	y:			NPI:						Tax ID:			
출음	Address:				City:						ST:		Zip:	
<u></u> =	Phone #:		F	ax #:				С	ontact	Email:				
2	Facility Name:						Facility 1	Fax ID	D:					
10 e	Address:				City:						ST:		Zip:	
шE	Phone #:		Fax							TRO	Date of Ser	vice:		
	ICD-9:	Please ci	rcle all that a	apply: CP	°T®Cod	de(s): C	T ABD:	7415	50 74	160 7	74170			
	C Mithaut Cont		72192 721			ER				and a second	and weiter of			
	Without Contr		t office visit of	With Co		ted cor	tact with		_ <u>LI</u> ,	vitnout	and With C	ontrast		
	physicia		e (format mm		oumen		naor with		Da	te		None		on't Know
		most recer			Г	Office		hone	call		ione call			Don't
	docume physicia	ented conta an?	ct with	Hospit		visit			staff		hysician	Email	Other	Know
			lvic pain pres	ent?						Yes		□ No		on't Know
		s the locati	on of pain? /	Above umb	oilícus o	or	Ab	ove	БΒ	elow	Both	No		on't Know
	5. Is this fo	or loft lower	quadrant pa	in?					╵╷┍┑	Yes		□ No	+	on't Know
5			dominal or pe		rv withi	in the p	ast year?		┤Ħ	Yes				on't Know
neti	Is fever	present?					.,			Yes		No		on't Know
for			d white blood	cell count	?					Yes		No		on't Know
5		o evaluate a								Yes		□ No		on't Know
Clinical Information		re unclear f	indings in pre	vious ima	ging stu	udies?	(CT, MRI	, Ultra	asound	l, X-	Yes	□ No		on't Know
5	ray) 11. Has the	re been un	explained or	unintentior	nal weid	aht loss	5?			Yes		□ No		on't Know
	12. Is there	a history o	f diverticulitis	?						Yes		No		on't Know
		atment with	antibiotics b	een done i	in the p	ast we	ek?			Yes		No No		on't Know
	CT Chest 14. Is this fo		rcle all that	apply : Ci	PT*Co	de(s):	71250	7128	10 71 Yes		1275 OT	HER		on't Know
			f cancer in th	e chest?				-++	Yes		No No			on't Know
			ule or mass o		ray or i	imaging	g study?		Yes		No No			on't Know
	17. Was a c	chest x-ray	done within t	he last 4 w	veeks a	nd rea	d by a rac	liolog			Yes	□ No)on't Know
			en done with	in the past	: year?				Yes		No			on't Know
		pain prese dimer bee						11	Yes	s bnorma		est Not		on't Know
	20. Hasa D	-amer dee	an dune:				Norma	1		unonnia)one		
20	Please check the	appropriat	e box descrit	bing you:			ering Phy	sician						
Pad Pad					Ļ	Facil								
					L				_					

	Please Sign and Date Below:	Responsible Contact:	
natur	Print Name:		Date:
Sig	Sign Name:		



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)
and a case. 693-3210. LIRGENT (Same Day) RECIESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693,3211

c	Patient First Name	T (Same Day) REC	LOCATA AP			ent Last Nan	ne	,			
M ember Iformatio	DOB:	Mbr ID:			Gro	up #:		He	alth Pla	n:	
Infor	Address:		City:				ST:	Zip	þ		
- 6	Physician First Name:				Phy	sician Last N	ame:				
ician Iafior	Primary Specialty		NPI:		Tax	ID:					
frysi form	Address:		City:				ST:	Zip	þ		
۳ ت	Phone #:		Fax #:		Con	tact Email:					
>	Facility Name:				Tax						
ne li	Address: Phone #:		City: Fax #:				ST: D Date of Ser	Zip	0		
<u> </u>	Phone #:		Fax #:				U Date of Ser	vice			
	ICD-9:	Please circle all t 70492 OTHER	hat apply:	CPT [®] Code(s): C1	CHEST: 712	250 71260 712	270 71	275 CT	NECK: 704	490 70491
	Without Contrast			With Contra				W	ithout ar	nd With Ca	ontrast
		ecent office visit or o Date (format mm/		ented conta	ct	Date		ΠN	one	🗌 Don't i	Know
	Type of most	recent			Тг	Phone call	Phone	call			Don't
	documented physician?	contact with	Hospital	visit		th office staf			Email	Other	Know
	Is this for canc			Yes			No No			Don't Know	1
		ice of cancer in the o		Yes			No			Don't Know	
Mion		nodule or mass on (□ No		<u> </u>	Don't Know	
Clinical Information		-ray done within the			y a r	adiologist?	Yes	No No		Don't Know	1
Info		T been done within t	the past yea	r?		Yes	No No			Don't Know	
ical	8. Is chest pain p			Yes		a harana a	No Test N			Don't Know	
le E	 Has a D-dimer Is this test to in 	nage the spine (nec	k bones or s	Nom Dinal cord		Abnormal Yes		ot Done		Don't Know Don't Know	
	11. Is cancer suspected?	Suspecter				nown History	Not Sus	spected		Don't Know	
	12. Is there a neck	mass?		Yes			No No			Don't Know	1
	13. Is the neck ma	ss painful?		🗌 Yes	1	No	Does N	lot App	y 🗆	Don't Know	,
	14. Has there beer	n difficulty or pain wi	ith swallowir	ng?		Yes	No No			Don't Know	1
	15. Is a thyroid pro	blem suspected?		Yes			No No			Don't Know	1
	16. Has a neck ult			Done		Planned	Neither	r		Don't Know	
	17. Is neck surger Please check the appro			Yes			No			Don't Know	1
Add Info	Flease check the appro	phate box describing	g you.			ng Physician	1				
₹.					acility ther						
•	Please Sign and Date	Below: Respons	ible Contac								
Signature	Print Name:					Dat	e:				
Sign	Sign Name:					D MD		LPN	□ PA		OTHER



MRA/CTA Head & 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.

	Patient F	Irst Name:				Pat	lent Last	Name	5								
Member Info	DOB:		Mbr ID:		Gr	oup #:						н	iealth	Plan:			
şē	Address:				City:							S	T:		Zip		
	Physician	n First Name:				Phy	sician La	ast Nai	me:								
	Primary (Specially:			NPI:							Т	ax ID	r.			
5		• •												-	_		
Physician Info	Address:			С	ity:							S	Т:		Zip:		
52	Phone #:			Fax #:				Conta	act Err	nall:							
	Facility N	ame:				Fac	ility Tax	ID:									
All .	Address:				City:	-							ST:		Zip:		
Facility Info	Phone #:		F	ax #:					RE	TRO	Date	e of Serv	lce:				
	Please	circle all that apply:	CPT®C	ode(s);	CTA HEA	D: 704	496 C); 70544	70545	70546	3
		ECK: 70547 70548									-						
	ICD-9:	U Without			With Q					Witho	ut a	and With	h Co	ntrast			
	1.	Date of most recent			documen	ted con	ntact wit	h	Date	e		_		None		n't Kno	w
	2	physician: Date (fo Type of most recent)ffice		none d	<u> </u>		hor	ne call	┼─	Email)on't
		documented contact		Hospit		sit		office				sician	ᆫ	C11121		Kno	
		physician?															
<u>ام</u>	3.		ad imaging	for this	problem v	vithin th			years	?	片	Yes	ᆝ님	No		on't Kn	
Ē	4.				nia?		Date				H	Other Yes	╎┤┤	None No		on't Kn on't Kn	
ê.		Is dementia or Alzhe			Dem	ientia		\ lzheir	mers			Both		Neither		on't Kn	
Clinical Information		suspected?									_						
울		Has there been a ne			c seizure?	, 					_	Yes	+=	No	1	on't Kn	
ō		Is there a history of									_	Yes		No		on't Kn	
	9.	treatment?			č			days	of		Ц	Yes		No		on't Kn	ow
		Has a trial of physic										Yes		No		on't Kn	
	11.	Has physician-direc	ted treatme	ent of at l	east 3 we	eks fai	led to h	elp the	e			Yes		No		on't Kn	w
	12	problem? When did treatment	start?	Less th	an 1 mon	th ago			No Tr	reatme	ent		<u> </u>	Don't K	new		
				More th	an 1 mon					not a		,					
		Can the patient walk		?							_	Yes		No		on't Kn	
	14.	Is there a known bra Has there been a kn	in tumor?		d) recent	eteeke e	TIA2				무			No No		on't Kn on't Kn	
		Is there a family hist						nem	,		븜	Yes		No		on't Kn	
	17.	Is there previous MF	R or CT he	ad imagi	ing for the	s proble	em?	ryann	-		Ħ	Yes	Ħ			on't Kn	
	18.	Has there been a re	cent evalu	ation by	a neurolo	gist or r	neurosu	rgeon	?		Ħ		Ħ			on't Kn	
		check the appropriate								acility			_			_	
	Please	Sign and Date Belov	w: Resp	onsible (Contact:												
Signature	Print Na	ame:							Da	ate:							
Sign	Sign Na	me:							MD		N [□ F		🗆 от	HER	



MRI and CT 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 (888) 693-3210.

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

<u>ر</u>	Patient First Name:					Patient	Last Na	me:						
Member Info	DOB:	Mbr ID:	:		Grou	p#:				H	lealt	h Plan:		
a t	Address:			Cit	y:					5	ST:		Zip	
	Physician First Name:					Physic	an Last	Name	2					
S	Primary Specialty:			NP	η: -					T	Fax I	D:		
Physician Info	Address:			City:						5	ST:		Zip:	
튚로	Phone #:		Fax #:				Cor	ntact l	Email:					
	Facility Name:					Facility	Tax ID:							
ality	Address:			Cit	y:						ST:		Zip:	
ΒĘ	Phone #:		Fax #:					D F	RETRO	Date o	of Se	rvice:		
	ICD-9:		Please circl 70551 705	e all th	at apply	: CPT [®] (Code(s):	MF					2 70543	3
	Without Contrast		10551 705		1003 U	/I: /U4	00 704	_	70470 Withou			_	st	—
	1. Date of most rece		visit or other	docum	ented co	ntact wit	ı	+		-		None		on't Know
	physician: Date 2. Type of most rece	e (format						Da			<u> </u>			
	documented cont physician?	act with	Hospit	al	Office visit	wit	Phone on office s		Pho with ph	ne call ysician		🗆 Email	□ Other	Don't Know
-	Is there previous					ast three	e years?		Yes		_	No		Don't Know
tion	4. Date of previous				d/yyyy)			Da				None		on't Know
Ë	5. Has there been re			gia?					Yes			No		Don't Know
Clinical Information	Is dementia or Ab suspected?	zneimer	s disease		🗆 De	mentia	🗌 Alzł	neime	rs 🗆	Both		Neither		Don't Know
lica.	Has there been a	new on:	set of epileptic	: seizur	e?					Yes		No		Don't Know
5	Is there a history	or migra	ines?							Yes		🗆 No		Don't Know
	9. Has there been p	ersistent	t unresponsive	e vertige	o despite	several	days of	treatr	nent?	ים	íes 🛛	□ No		Don't Know
	10. Has a trial of phys	sician-di	rected treatme	ent beer	n comple	ted?				ים	íes 🛛	□ No		Don't Know
	 Has physician-dir 							robler			íes -	No No		Don't Know
	12. When did treatme start?		Less than 1 Ionth ago		More that onth ago	an 1	□ No Treatm	ent		oes n	ot ap	ply [Don't	Know
	13. Can the patient w									Yes		No		Don't Know
	14. Is there a known	brain tun	nor?							Yes		No		Don't Know
22	Please check the	appropr	iate box descr	ribing y	ou:	Ordering	Physici	an						
Add Info						Facility Other								
	Please Sign and Date Bel	ow: F	Responsible C	ontact:										
Signature	Print Name:							Date:						
Sign	Sign Name:						ШМ		RN 🗆	LPN [] P/		P 🗆 01	THER



CT Maxillofacial Imaging Request

PRI-SM

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.

	Patient First Name:			Patient La	st Name:		
ę.	DOB: Mbr	D:	Gr	oup #		Health Plan:	
Member Info	Address:		City:			ST:	Zip
	Physician First Name:			Physician	Last Name:		
۲.	Primary Specialty:		NPI:			Tax ID:	
sici	Address:	(City:			ST:	Zip:
Physician Info	Phone #:	Fax #:	-		Contact Email:		
	Facility Name:	I		Facility Ta	x ID:		
lity	Address:		City:			ST:	Zip:
Facility Info	Phone #:	Fax #:			RETRO Da	te of Service:	1
	ICD-9: Please circle a	I that apply: CPT	'Code(s):	70486 704	87 70488 OT	HER	
	Without Contrast	With Co				nd With Contras	it
R	 Date of most recent office Date (format mm/dd/yyyy) 	visit or other docun	nented con	act with phys	ician:		
Clinical Information	Type of most recent docu			?			
nfon	Hospital	Phone call v Email	with physici	an 🗌 Dont	KNOW		
	Phone with office start						
Ĭ	 Is head or neck cancer su Is there a history of heada 	spected?					on't Know on't Know
0	-						
	 Is there a history of asthm 0. Is there a history of chroni 				Yes Yes		on't Know on't Know
	 Is there a fisibly of children Is this a repeat episode of 				Yes		on't Know
	 Are there findings of period 						on't Know
	 Has there been failure to 		cian directe	d treatment?			on't Know
	10. Has there been failure to						on't Know
	supervised treatment for			priysionan			
	 Was a second antibiotic u treatment was unsuccess 	sed if the first cour	rse of antibi	otic	Yes	No Do	on't Know
	12. Has a specialist evaluatio						
			eurologist		Other:		
	Allergist		eurosurgeo	n	Don't Know		-
	Pulmonologist						
	Please check the appropriate bo	x describing you:		rdering Physi	cian		
Add Info		•••		acility			
₹5				ther			
	Please Sign and Date Below:	Responsible Cor	ntact:				
Signature	Print Name:				Date:		
R.							
ŝ	Sign Name:					LPN 🗌 PA 🗌	NP OTHER

IMPORTANT WARNING – This information is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this fax by error, please notify the phone number above immediately and destroy the fax.

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MEDSOLUTIONS

PRI-SM

CT Maxillofacial & 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.

	Patient First Name:		Patient Last Name:					
Member Info	DOB: Mbr ID	-	Group#:		Health Plan:			
Me	Address:	City:		ST:	Zip			
	Physician First Name:	•	Physician Last	Name				
5	Primary Specialty:	NPI:	1	Tax ID:				
rsician	Address:	City:		ST: 2	Zip			
ĘĘ	Phone#:	Fax#:	Contact	Email:				
	Facility Name:		Tax ID:					
18.0	Address:	City:	S	ST: 2	Zip			
22	Phone#: Fa	ax#:	RETRO Da	te of Service:				
	ICD-9: Please circle a CT Maxillofaci	ill that apply: CPT [®] Code(s): CT NE al: 70486 70487 70488 OTHE	CK: 70490 70	491 70492				
	Without Contrast	With Contrast		Without	t and With Contrast			
	 Date of most recent office contact with physician: 	e visit or other documented Date (format mm/dd/yyyy)	Date	□ None	Don't Know			
	Type of most recent docu contact with physician?	umented D Office Hospital visit	Phone call with office staff	Phone call with physician	Email Other Know			
1	Is head or neck cancer s	uspected?	☐ Yes	□ No	Don't Know			
	Is there history of heada	ches?	Yes	No	Don't Know			
	Is there a history of asthr	na?	Yes	No	Don't Know			
	Is there a history of chror		Yes	No	Don't Know			
5	Is this a repeat episode of		Yes	No	Don't Know			
je j	 Are there findings of peri 	orbital cellulitis?	☐ Yes atment? ☐ Ye	es No	Don't Know			
Ę.	 Has there been failure to 10. Has there been failure to 	improve after a 4 week trial of physic	ician supervised		No Don't Know			
E.	treatment for sinusitis?							
Clinical Information	11. Was a second antibiotic unsuccessful?	used if the first course of antibiotic tr	eatment was	□ Yes [No Don't Know			
2	12. Has a				Don't			
	specialist nose a	and Allergist Pulmonologist	Neurologist	Neurosurgeon	No Other Know			
	evaluation throat							
	been done? (ENT) 13. Is this test to image the s	reine?	Yes	N₀	Don't Know			
	14. Is cancer suspected?	Suspected, not confirmed	Known History		ected Don't Know			
	15. Is there a neck mass?	cuspedica, not commed	Yes		Don't Know			
	16. Is the neck mass painful	? Does not apply	Yes	No	Don't Know			
	17. Has there been difficulty		Yes	No	Don't Know			
	Is a thyroid problem susp		Yes	No	Don't Know			
	19. Has neck ultrasound bee			Planned	Neither Don't Know			
	20. Is neck surgery planned? Please check the appropriate box		ering Physician	□ No	Don't Know			
Add	Please check the appropriate box	Gescholing you.	lity					
	Please Sign and Date Below:	Responsible Cont						
Signature	Print Name:		Date:					
Sig	Sign Name:							



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.

	Patient F	First Name:					Patient La	st Narr	ie:		
Member Info	DOB:		Mbr ID:			Grou	p#			Health Plan:	
Me	Address				City:					ST:	Zip
	Physicia	n First Name:					Physician	Last N	ame:		
c	Primary	Specialty:			NPI:					Tax ID:	
Physician Info	Address				City:					ST:	Zip:
Ϋ́́	Phone #	-		Fax #:				Cont	act Email:		
	Facility N	Name:					Facility Ta	x ID:			
All III	Address	:			City:					ST:	Zip:
la B B	Phone #	-		Fax #:	-				RETRO	Date of Servi	De:
	ICD-9:			Please circle a	all that a	pply: (CPT [®] Code(s): 70	490 70491 70	492 OTHER	
	U Wit	hout Contrast		With Con	trast				Without an	d With Contra	ast
	1.	Date of most rece physician: D		visit or other do at mm/dd/yyyy		ed cor	tact with		Date	□ None	Don't Know
	2.	Type of most rece documented cont	ent	Hospital	Ú U Ofi visi		Phone c office staff			Email	Other Don't
afior	3	physician? Is this test to image	ne the sni	ne?		\rightarrow	□ Yes		physician No		Enow Don't Know
form		Is cancer suspect		Suspected	l, not			Linter	+		
Clinical Information	5.	Is there a neck m	3662	confirmed				HISIOTY		pecied	-
inik		Is the neck mass					Yes		□ No		Don't Know
0			-		_				Does not	apply	Don't Know
		Has there been d			llowing?		□ Yes		□ No		Don't Know
	9.	Has a neck ultras					Planned	•	No Not Don	e or Planned	Don't Know
		Is neck surgery p					Yes			e or r familiea	Don't Know
-		0.71									
afion	Please o	heck the appropri-	ate box de	escribing you:			Ordering Ph	vsiciar	1		
(dditti fiorm							Facility Other				
۲							Other				
	Please \$	ign and Date Bel	ow: R	esponsible Co	ntact:						
Signature	Print Na	me:						Da	ate:		
Sign	Sign Nar	me:					[MD		PN 🗌 PA 🗌	



CT Spine Imaging Request

PRI-SM

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.

Participation Participation DOB: Mbr ID: Group # Health Plan: Address: City: ST: Zip Physician First Name: Physician Last Name: Physician Last Name: Primary Specialty: NPI: Tax ID: Address: City: ST: Zip: Phone #: Fax #: Contact Email: Facility Name: Fax #: Contact Email: Address: City: ST: Zip: Phone #: Fax #: Contact Email: Facility Name: Fax #: Contact Email: Phone #: Fax #: Contact Service: ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Uwithout Contrast With Contrast With Contrast Without and With Contrast Date of most recent office visit or other documented contact with physician: Don't Know Zip Phone and With Physician Date (format mm/dd/yyyy) Phone call with physician Don't Know	72130
Physician First Name: Physician Last Name: Primary Specialty: NPI: Tax ID: Address: City: ST: Zip: Phone #: Fax #: Contact Email: Facility Name: Facility Tax ID: Address: City: ST: Zip: Phone #: Fax #: Contact Email: Address: City: ST: Zip: Phone #: Fax #: Contact Email: ST: Zip: Phone #: Fax #: Contact Email: ST: Zip: Phone #: Fax #: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Uthout Contrast With Contrast Without Contrast Without contrast In Date of most recent office visit or other documented contact with physician: Don't Know 2. Type of most recent documented contact with physician? None Don't Know	72130
Primary Specialty: NPI: Tax ID: Address: City: ST: Zip: Phone #: Fax #: Contact Email: Facility Name: Fax #: Contact Email: Facility Name: Fax #: Contact Email: Address: City: ST: Zip: Phone #: Fax #: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT® Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Uthout Contrast Without Contrast Without and With Contrast Without and With Contrast 1. Date of most recent office visit or other documented contact with physician: Don't Know 2. Type of most recent documented contact with physician?	72130
Facility Name: Facility Tax ID: Address: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Without Contrast With 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)	72130
Facility Name: Facility Tax ID: Address: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Without Contrast With 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)	72130
Facility Name: Facility Tax ID: Address: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Without Contrast With 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)	72130
Address: City: ST: Zip: Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT® Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Without Contrast With 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? None None None	72130
Phone #: Fax #: RETRO Date of Service: ICD-9: Please circle all that apply: CPT® Code(s): (C-Spine) 72125 72126 72127 (T-Spine) 72128 72129 Without Contrast With 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? None Don't Know	72130
ICD-9: Please circle all that apply: CPT* Code(s): (C-Spine) 72126 72126 72127 (T-Spine) 72128 72129 Uithout Contrast With 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?	72130
(L-Spine) 72131 72132 72133 OTHER Without Contrast With Contrast With Contrast With Contrast Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyy) On't Know Z. Type of most recent documented contact with physician?	72130
Without Contrast With Contrast With Contrast With Contrast Without and With Contrast None Don't Know Type of most recent documented contact with physician?	
Date (format mm/dd/yyyy)	
Type of most recent documented contact with physician? Hospital Phone call with physician Don't Know	
Hospital Phone call with physician Don't Know	
Office visit Email	
 Phone call with office staff Other What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)? 	
Date (format mm/dd/yyyy) Date (format mm/dd/yyyy)	
Date (format mm/dd/yyyy)	
4. Has a specialist evaluation been performed? Yes No Don't Know 5. Did the specialist generate this request? Yes No Don't Know	
5. Did the specialist generate this request? Yes No Don't Know	
 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 	1
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 – <u>myelogram</u> or <u>discogram</u> ? Yes No Don't Know	
10. Is there an abnormal neurology exam?	
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	
Please Sign and Date Below: Responsible Contact:	
Print Name: Date: Sign Name: MD	

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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) 633-3210. URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 633-3211.

3a	Patient First Name:			Patient Last Name		
ŧ.	DOB:	Mbr number:		Group #:	Health Plan	1:
₹ K	Address:	City:		ST:	Zip	
	Physician First Name:		Physi	cian Last Name:		
Physician Info	Primary Specialty:	NPI:		Tax ID:		
veio V	Address:	City:		ST:	Zip:	
£3	Phone #:	Fax #:		Contact Email:		
	Facility Name:			Tax ID:		
À III	Address:	City:		ST:	Zip:	
2 ž	Phone #:	Fax #:			O Date of Se	ervice:
	Please circle all that apply: CPT [®] Code(s)	CT NECK: 70490 7	0491 70	492 OTHER		
	ICD-9: Without Con	ntrast 🗌 With (Contrast	Wit	nout and With	Contrast
	 Date of most recent office visit or o contact with physician: Date (for 		Date		None	Don't Know
	2. Type of most recent documented		Pho	ne call D Phone	call	Don't
	contact with physician?	Hospital visit	with off	ice staff with phys	ician Email	Other Know
	Is this test to image the spine (nec			Yes		Don't Know
	 Is cancer suspected? S Is there a neck mass? 	uspected, not confirmed		nown History	vot Suspected	
				Yes No		Don't Know
	Is the neck mass painful?	☐ Yes		No Doe	s Not Apply	Don't Know
	Has there been difficulty or pain with the second second	th swallowing?		Yes 🗌 No		Don't Know
	Is a thyroid problem suspected?			Yes 🗌 No		Don't Know
Ŋ	 Has a neck ultrasound been: 	Done P	lanned	Neither		Don't Know
mal	10. Is neck surgery planned? ICD-9: Please circle all that ap	alu: CDT [®] Cada/a): ME	I HEAD:	Yes 70336 70540 7	No 0542 70543	Don't Know 70551 70552
Clinical Information	70553 CT HEAD: 704	150 70460 70470 7	0496 O		0042 70043	10001 10002
	11. Is there previous head imaging for	this problem within the pa	ast three	Yes	No	Don't Know
- E	years? 12. Date of previous head imaging?	Date		Don't Know	Other	None
Ŭ	Has there been recent onset of here	miplegia?			No	Don't Know
	 Is dementia or Alzheimer's disease suspected? 	e 🗌 Demer	ntia 🗖	Alzheimers 🛛 🛛 B	oth 🗌 Neith	ner Don't Know
	15. Has there been a new onset of epi	ileptic seizure?		☐ Yes 1	No	Don't Know
	16. Is there a history of migraines?			-		Don't Know
	17. Use there been exercision increase	arius untine deceile cou	anal dava			
	 Has there been persistent unresponse Has a trial of physician-directed tree 					
					_ No TYes I ∏No	Don't Know
	19. Has physician-directed treatment of 20. When did treatment	s than 1 More t			Does not	Don't Know
	start? month			Treatment	apply	
	21. Can the patient walk normally?				Yes No	
	22. Is there a known brain tumor? Please check the appropriate box describin	a usur 🔲 Ordanian B	hurinian	Facility	Yes No Other	Don't Know
			nysician		Other	
2	Please Sign and Date Below: Respon Print Name:	sible Contact:		Date:		
18th						
Sign	Sign Name:		_ 🗆 M			IP 🗌 OTHER

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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.

ž	Patient First Name:				Patient Las	t Nam	ie:					
Vlember Info	DOB: Mb	r ID:		Group	#:			He	alth Pl	an:		
Men Info	Address:		City:					ST	:	Zip		
	Physician First Name:				Physician L	ast N	ame:					
an	Primary Specialty:		NPI:					Та	x ID:			
Physician Info	Address:		City:					ST	:	Zip:		
h L L L	Phone #:	Fax #:				Cont	act Email:					
	Facility Name:				Facility Tax	ID:						
ility	Address:		City:	I				ŝ	ST:	Zip:		
Fac Info	Phone #:	Fax #:					RET	RO E)ate of	Service:		
	ICD-9:	Please circle all								156		
	Without Contrast	(T-Spine) 72146		72157	(L-Spine)	72148				Contrast	-	
	 Date of most recent office 	e visit or other docum		ntact wit	h			outun				Don't Know
	physician: Date (forma 2. Type of most recent docu			Office	☐ Phone	Date	Phone	v call				Don't
	contact with physician?	Hospit	al	visit	with office	staff	with phys	ician	Ema		her	Know
	What was the date of the pain, neck pain, etc.)?	FIRST office visit for	this epis	ode of s	ymptoms (ba	ck	This is t first visit for		Date			Don't Know
	Date (format mm/dd/yyyy						episode		_			
	 Is there previous imaging 	-					Yes					Don't Know
	5. Is there a personal histor	<i>,</i>		<u> </u>	ncer? 4 weeks or	Π6	Ves veeks	∏ 8 or		No		Don't Know
c	6. Has there been failure to treatment?	Improve with physicia	an directi	ed les:				more w	ks	Treatme	nt	Know
natio	 In the last two months, has A motor vehicle accident 							No iniur	y or trai	uma		
Clinical Information	 A fall from a height Other injury or trauma: 	`´́ 🗖 A he			oss of consci	ousnes		Don't K				
<u>a</u>	8. Is the imaging request re		pain?				□ Yes			, Г		on't Know
Clini	MRI/CT Head Please circle 70450 70460 70470 70496	all that apply: CPT®	Code(s)	MRI:	70336 70)540	70542 705	43 7	0551	1 -		3 CT:
	9. Is there previous head in		n within t	he past	three years?			🗌 Ye	s [No [D	on't Know
	Date of previous head im				Date				i't Know	-	No	
	 Has there been recent or 12. Is dementia or Alzheimer 		0		mentia	Alzhe	Yes	Both	_ No 			on't Know on't Know
	13. Has there been a new on						Ves					on't Know
	14. Is there a history of migra		•.				☐ Yes		No			on't Know
	15. Has there been persisten		o despite	e several	days of treat	ment?			/es	□ No		Don't Know
	Has a trial of physician-di						Yes		No			on't Know
	 Has physician–directed tr 						T ()	☐ Yes				on't Know
	When did treatment start?	Less than 1 mor	ntn	iviore th	an 1 month		o Treatment		oes not	t apply		Don't Know
	15. Can the patient walk norn	nally?					Yes	- [No	[D	on't Know
	16. Is there a known brain tur						Yes	[No	[D	on't Know
	Please check the approp	riate box describing y	ou: 🗌	Orderin	g Physician	🗆 Fa	acility 🗌	Other			-	
	Please Sign and Date Below: F	esponsible Contact:										
Signature	Print Name:				Date:					_		
Sig	Sign Name:						LPN P		NP 🗆	OTHER		

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MRI Abdomen 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.

F	Patient First Name:		Patient Las	st Name:		
a pe	DOB: Mbr ID:	Grou	ip #		Health P	lan:
Member Info	Address:	City:			ST:	Zip
	Physician First Name:		Physician I	ast Name		
Physician Info	Primary Specialty:	NPI:			Tax ID:	
ifo if	Address: C	City:			ST:	Zip:
27	Phone #: Fax #:			Contact Email:	•	
y	Facility Name:		Facility Tax	(ID:		
Facility Info	Address:	City:			ST:	Zip:
шĘ	Phone #: Fax #:				Date of Servi	ce:
	ICD-9: Please circle all that apply: CPT	© Code(s):				
	Without Contrast With Contrast With Contrast Under the second office visit or other docum	ented conta	ct with physi	Vithout and With Co	ontrast	
	Date (format mm/dd/vvvv)		None 🗍 Do			
	Type of most recent documented contact with	n physician?				
	☐ Hospital	ith physiciar/	n 🗌 Do	n't Know		
	Phone with office staff Other					
	3. Is there a reason to avoid CT contrast?			Yes	No No	Don't Know
	4 la a linema avenastado					Den't Know
ion	Is a lipoma suspected?			Yes	🗌 No	Don't Know
ormal	5. Are there unclear findings on a previous ultra	sound?		Yes	No No	Don't Know
al Info	6. Is there a current pregnancy?			Yes	🗌 No	Don't Know
Clinical Information	7. Is this for right lower quadrant pan with assoc	ciated fever?)	Yes	No 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-Abo	domen imagi	ing?	Yes	🗌 No	Don't Know
	11. Is this for right upper quadrant pain with asso	ciated fever	?	Yes	No No	Don't Know
	12. Is jaundice present?			Yes	No No	Don't Know
	13. Is the AFP elevated?			Yes	No No	Don't Know
	14. Is the study to evaluate a liver lesion?			☐ Yes	No No	Don't Know
	Please check the appropriate box describing you:	Orc	dering Physic	cian 🗌 Facility	/ Oth	er
	Please Sign and Date Below: Responsible Con	tact:				
ure	Print Name:			Date:		
Signature	Sign Name:		[
0)						

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PRI-SM

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MRI Abdomen & 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

UNGENT (Same Day) REQUESTS ARE ACCEFT	LED BI FHONE ONLY AT (666) 650-0211.
nt First Name:	Patient Last Name:

Member Info	DOB:	Mbr ID:				Group	, #·				He:	alth Plan:		
lem Ifo	Address:	NUDI ID.		Citv:		Group	, π.		ST		Zip	alut Fiari.		
2 =				Oity.										
	Referring/Requesting Physician F	-irst Nam	e:			Refer	ring	Requ	estin	ng Physician	Last	Name:		
an	Primary Specialty:		NPI:			Tax II	D:							
Physician Info	Address:		City:						ST:		Zip			
Phy	Phone #:		Fax #	:		Conta	ict E	mail:						
	Facility Name:					Facili	v Ta	ax ID.			_			
lity	Address:		City:			- doin	., .,		ST:		Zip			
Faci Info	Phone #:		Fax #					ΤН	RE	TRO Date	of Ser	vice:		
	ICD-9: Please cir				T [®] Oada(a)		A In al			4181 7418				
	MRI Pelvi				2197 OT		ADa	omen	: /	4181 7418	2 74	183		
	Without Contrast				ontrast			[V	Vithout and	With	Contrast		
	 Date of most recent office 									None			Don	i't Know
	2. Type of most recent door			mm/dd	(yyyy)	Dat		ne ca	_	Phone c	all			Don't
	contact with physician?		Ho	spital	visit	wit	n off	ice sta		with physici		Email	Other	
	Is there a reason to avo	id CT cor	ntrast (allergy	to contrast	materi	al oi	renal		Yes	\square	No No	Dor 🗌	n't Know
	failure)? 4. Is a lipoma suspected?							Yes		□ No				n't Know
	5. Are there unclear finding	as on pre	vious ı	ultrasou	nd?		H	Yes						i't Know
Clinical Information	Is there a current pregn						Yes						n't Know	
nat	Is this for right lower quality			ated fever?)		Yes		No No			Dor	n't Know	
om	Is this to evaluate for ca	uses of h	ematu	ria?				Yes		No No				n't Know
12	Is pain present?							Yes		No No				n't Know
8	Are there unclear finding							Yes		No No				n't Know
ini	11. Is this for right upper qu	adrant pa	ain with	1 associ	ated fever	?	<u> </u>	Yes						n't Know
0	12. Is jaundice present?						<u> </u>	Yes						n't Know
	13. Is the AFP elevated?	- 11					<u> </u>	Yes						n't Know
	14. Is the study to evaluate			TDate			⊢⊢	Yes						n't Know
	15. Are there unclear finding				s imaging?		⊢⊢	Yes						n't Know n't Know
	 16. Is this for pre or post su 17. Is a UAE planned? 	igery eva	luation	17			⊢	Yes Yes						n't Know
	I.									_				
	18. Has a UAE been comple							Yes		□ No				n't Know
	Is abnormal uterine or v	0		•			_	Yes		No No			_	n't Know
	20. Has there been a period Hormones)?	l of conse	ervativ	e treatm	ent (Birth (control	pills	or		Yes		No	Dor	n't Know
	Please check the appropriate box	describi	na voi	1	Ordering	1 Phys	icia	n						
Add Info				[Facility	,,.								
∀ =				[Other			_						
e	Please Sign and Date Below:	Respor	nsible (Contact										
atur	Print Name:													
Signature	Print Name:							0	ate:					
S	Sign Name:							MD		RN 🗌 LPN	P	A 🗌 N	P 🗌 O	THER



MRI and CT 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 (888) 693-3210.

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

<u> </u>	Patient	First Name:						Pa	itient La	st Nan	ne:							
Member Info	DOB:		Mbr ID:	:			Grou	p #:						Hea	alth Plan	:		
Mei Info	Address					City	r.							ST:		Zip)	
		an First Name:						Ph	iysician	Last N	lame							
an	,	Specialty:				NPI	E							Тах		_		
Physician Info	Address	5:				City:								ST:		Zip	D:	
Phy Info	Phone #	<i>t</i> :		F	ax #:					Cont	act E	Email:						
	Facility I							Fa	cility Ta	ix ID:								
Facility Info	Address					City	/:							S	T:	Zip): 	
Fai	Phone #	ŧ:		Fax #	#:						R	ETRO	Date	of S	ervice:			
	ICD-9:				se circle a 51 70552							l: 703 70470			0 705 Other	42	70543	
	□ Wi	thout Contrast			With Contr		000 -	<u>, .</u>	10400	1040					th Contra	ast		—
	1.	Date of most rece		e visit o	or other do		nted cor	ntact	t with				/u] None	A.C.		on't Know
	2.	physician: Date Type of most rec	e (format ent	i mm/d	1						Da			-	_	-		
		documented cont physician?	tact with		□ Hospital	I	Office visit		with of				one ca		Email	O)ther	Don't Don't Know
~	3.	Is there previous						bast f	three ye	ears?		Yes			No		D	on't Know
atior	4.	Date of previous		0 0	`		/уууу)				Da				None			on't Know
orme	5.	Has there been r				a?						Yes		ļĽ	No		DD	on't Know
Clinical Information	6.	Is dementia or Al suspected?					🗌 Dei	men	ntia 🗌	Alzhe	eime	rs [Both		Neith	er	D	on't Know
nice	7.	Has there been a			epileptic s	eizure	:?				_		Yes		No		D	on't Know
Ü	8.	Is there a history	or migra	ines?] Yes			10	DD	on't Know
	9.	Has there been p			•	Ŭ				ys of tr	reatn	nent?		Yes		10	D	on't Know
	10.	Has a trial of phy					•							Yes		ю	D	on't Know
	11.										bler			Yes		١٥		on't Know
	12.	When did treatme start?		_ Less nonth a	s than 1 ago		More tha nth ago	an 1] No reatme	nt		Does I	not a	pply		Don't k	<now< th=""></now<>
	13.	Can the patient w			igo		larago			Cauna	an.		Yes] No		D	on't Know
	14.	Is there a known	brain tur	nor?									Yes		No		_ D	on't Know
p g		Please check the	e appropr	riate bo	ox describ	oing yo			ering Pl	hysicia	n							
Add Info								Faci Othe				_						
ø	Please S	Sign and Date Bel	low:	Respo	onsible Cor	ntact:												
Signature	Print Na	ime:							_	D	ate:							
Sig	Sign Na	me:							[RN 🗌] LPN	F	PA 🗆 I	NP	🗆 от	HER

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PRL-SM Breast MRI 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.

	Patient	First Name:						Patie	ent Last I	Van	ne:						
Member Info	DOB:		Gender:	M / F	- 1	Mbr ID:			Group	#				H	ealth Plan	:	
Mei Info	Address	6			(City:					ST:			Zi	р		
ç	Physicia	n First Name						P	nysician	Las	st Nam	ne:					
Physician Information	Primary	Specialty:				NPI:					Tax IC):					
iysic	Address	6				City:					ST:			Zi	р		
년 1	Phone #	ŧ				Fax #:		Cont	act Ema	il:							
	Facility I	Name:						Tax	D:								
Facility Info	Address					City:					ST:			Zi	р		
Fa	Phone #	ŧ				Fax #:					RET	RO	Date of	Se	ervice:		
	ICD-9:							l that ap	ply: CP	т®	Code(s): I			t: 77058		
	1.	Date of most contact with		ce visit	or oth	her docu	Imented	Dat	e				Do Do	n't l	Know	□ No	ne
	2.	Type of mos			Office	Phon	e call				call wit	h			Don't		
		Is this an annual or screening M			Hosp I	oita vis	sit	with c	office sta	Π		hysic	lan		Email	Other	Know
~	3.	Is this an annual or screening M Is there a history of breast cance				(Hint: n	o breast l	esion or	problems	5)	ı 🗌	′es	No)	Don't	Know	
atior	4.	Is there a his	story of brea	ast can	cer?						ו 🗆	′es	□ No)	Don't	Know	
orm	5.	lesion? mass					Yes mass o		☐ Ye mass				revious		on RI or CT		Don't
Clinical Information		lesion? mass (choose all that apply) physi				sical	Mammo		Ultras		d	1	ne vious	> 111		No	Know
linic	6.	Date of last i	imaging		exa	m		formed b	etch tu				Linknov	vn i	if imaging		revious
o	0.	study?	inaging				unknow		ui uaic				was pe			imag	ing not
	-	1		Date_												done	
	7.	Is a breast b	liopsy planr	ied?						_	□ Y	′es		N	10		on't Know
	8.										<u> </u>			<u> </u>			on't Know
	9.	Has a breast Is there a ne								_		'es			10		on't Know
											□ Y	'es		N	10		on't Know
Add Info	Please	check the app	oropriate bo	x descri	ibing	you:		rdering acility	Physicia	n							
Α'n							Do	ther		_							
ø	Please	Sign and Dat	te Below:	Res	pons	ible Con	itact:										
Signature	Print Na	ame:								D	ate: _						_
Sig	Sign Na	ime:								MD		N 🗆	LPN [F		• 🗆 o	THER



MRI Knee 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) case case. 693-3210.

	URGENT (San	ie Day) REQU	JESTS A					NLY AT (888) 693-3211.	
	Patient First Name:			F	Patient	Last Nar	ne:			
Member Info	DOB: Mbr ID):		Group	#			1	Health Plan:	
Mei Info	Address:		City:					:	ST:	Zip
ū	Physician First Name:			ŀ	Physici	an Last N	lame:			
cian ìatio	Primary Specialty:		NPI:	I				-	Tax ID:	
Physician Information	Address:		Ċity:					:	ST:	Zip:
	Phone #:	Fax #:					act Ema	ul:		
	Facility Name:		Oit	F	Facility	Tax ID:			OT:	7:
Facility Info	Address: Phone #:	Fax #:	City:						ST:	Zip:
Fa	Phone #.	Fax #.					🗌 R	ETRO Date	of Service:	
	ICD-9:	Please circl	e all that	apply:	CPT	Code(s)	7372	1 73722 737	23 OTHER	
	Without Contrast	U With Co					ΠW	ithout and Wit	th Contrast	
	 Date of most recent offi physician: Date (form 			ented co	ontact	with	Date		🗌 None	Don't Know
	Type of most recent do	cumented con	tact with p						.1	
	Hospital		ne call wit ne call wit			Em Oth] Don't Know		
	3. What was the date of th	e FIRST office	e visit for			the Greek	Da			
tion	this episode of sympton Date (format mm/dd/yyy		etc.)?			the first s episode		ee Text:		_ Don't Know
rmai	 Has a specialist evaluat completed? 		Orthope	edist		Sports Medicin		D Podiatrist	□ No	Don't Know
Clinical Information	5. Has there been a recen	t injury?	l w	ithin pa	ast 2			han 2 Months	s 🗌 No	Don't Know
linic	6. Has an X-ray been done	e?	- MO	/1013				🗌 Yes	□ No	Don't Know
0	Is there a personal histor	ory of cancer o	ther than	ordina	ry skin	cancer?		🗌 Yes	□ No	Don't Know
	Is this study to evaluate	arthritis?						🗌 Yes	□ No	Don't Know
	Are the knee ligaments	stable upon e	xaminatio	n?				🗌 Yes	🗆 No	Don't Know
	10. Is there a positive McM	urray test?						🗌 Yes	🗌 No	Don't Know
	11. Does the knee have full	extension upo	on examir	nation?				🗌 Yes	🗆 No	Don't Know
	 Has there been a period conservative treatment? 		3 wee		4 weeks	6 week		8 weeks or more	Non	e 🗌 Don't Know
	Please check the appropriate bo					ering Phy		of more		
Add Info					Faci					
								_		
ø	Please Sign and Date Below:	Responsible	e Contact	-						
Signature	Print Name:						Date	:		
Sigr	Sign Name:					_ 🗆	MD 🗌	RN 🗌 LPN		



MRILE & UE Joint 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.

	Patient First Na	me:						Patient	Las	st Name:						
Member Info	DOB:		Mbr ID:				Grou	p#					Healt	th Plan:		
Men Info	Address:					City:							ST:		Zip	D
	Physician First	Name:						Physici	an l	_ast Nam	ne:					
Physician Information	Primary Special	Ity:				NPI:							Tax I	D:		
Physician Informatio	Address:					Ċity:							ST:		Zip	D:
Phy Info	Phone #:			Fax	(#:					Contact	Em	ail:				
	Facility Name:							Facility	Тах	(ID:						
Facility Info	Address:					City:							ST	:	Zip	D:
Fac Info	Phone #:			Fax #:] RETRO	Date	of Service	e:	
	ICD-9:	Please ci 73723 O		that ap	oply: CPT	Code(s): N	IRI UE J	OIN	IT: 7322	1 7	3222 73223	3 MF	RI LE JOII	NT:	73721 73722
	U Without Co			□ w	/ith Contras	st] Without ar	nd Wit	th Contras	st	
		of most recer format mm/c			other docu	menteo	i conta	act with p	hys	ician:	Da	to		□ None	,	Don't Know
	2. Type of	of most rece		mented	contact wi	th phys	ician?		_				_		,	Dontraiow
	Hospi	e visit		- F	Phone call Phone call	with ph			Em Oth			n't Know				
tion		was the date isode of syn					Date					This is the f sode	irst vi	sit for this		Free text:
ama	pain, e	etc.)? Ďa	ate (form	nat mm	/dd/yyyy)							Don't Knov	v		_	
l Info		specialist ev			completed	?						Yes		🗌 No		Don't Know
Clinical Information	5. Hasth	ere been a i	recent in	njury?								Yes		🗆 No		Don't Know
o	6. Hasar	n X-Ray bee	n done?	?								Yes		🗌 No		Don't Know
	7. Is then	e a PERSOI	NAL hist	tory of o	cancer othe	er than (ordina	ry skin ca	ance	er?		Yes		🗌 No		Don't Know
	8. Is this	study to eva	aluate ar	thritis?								Yes		🗌 No		Don't Know
	9. What i	s the range	of motio	n?	🗌 Full N	/lotion	1			Limited/	Pai	nful		1		Don't Know
		ere been a j rvative treatr		ſ	3 weeks o	or less	□ 4 we	eeks		6 week	s	0 8 weel or more		I No treatmen	nt	Don't Know
ъg	Please check th	ne appropria	te box d	lescribir	ng you:			rdering P acility	hys	sician						
Add Info								ther								
	Please Sign an	nd Date Bel	ow: F	Respon	sible Conta	act:										
ature	Print Name:									Date:						-
Signature	Sign Name:										RN		PA [NP 🗌] 0	THER



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. IIDGENT (Some Dov) RECILESTS ARE ACCEPTED BY RUCKE ONLY AT (999) 693-3911

	Patient First Name:		ARE AGGET I			Last Nar	(888) 693-32		
ي آھ	Fallent Fist Name.				Fallent	Lastinai	ne.		
Member Information	DOB:	Mbr ID:		I		Group	#:	Hea	ith Plan:
M Info	Address:	•	City:				ST:		Zip
- F	Physician First Name:			Phys	sician La	ast Name	2:		
Physician Information	Primary Specialty:		NPI:			Tax ID:			
hy	Address:		City:			ST:			Zip:
	Phone #:		Fax #:			Contac	t Email:		
y	Facility Name:					Tax ID:			
icili Ifo	Address:		City:			ST:			Zip:
Fa I	Phone #:		Fax #:			RE	TRO Date of	Service:	
	Please circle all that apply: CPT [®] Co MRA HEAD: 70544 70545 70546 7				70542	70543	70551 705	52 705	53
	ICD-9: Without Contras			Contrast			U Witho	out and	With Contrast
	 Date of most recent office visit or oth Physician: Date format (mm/dd/y 		ed contact with	Date			None		Don't Know
	Type of most recent documented cor physician?	ntact with	Hospital Visi		Phone Nith office		Phone call with physician	□ Email	Other Know
	 Is there previous head imaging for th 	is problem wi					☐ Yes	□ No	Don't Know
	Date of previous head imaging? Date	e format (mm/	/dd/yyyy)	Date			Don't Kno	w [Other None
tion	 Has there recent onset of hemiplegia 			<i></i>				NI 34	Don't Know
mai	6. Is dementia or Alzheimer's disease s 7. Has there been a new onset of epile			mentia	Alzh			Neither	Don't Know
Clinical Information	8. Is there a history of migraines?	blic seizure?				Yes Yes			Don't Know Don't Know
lical	 Has there been persistent unrespons 	sive vertigo de	espite several da	ys of treat		163	☐ Yes	□ No	Don't Know
lin	10. Has a trial of physician-directed treat	ment been co	mpleted?	-		Yes			Don't Know
0	 Has a that of physician directed treat 11. Has physician-directed treatment of a 			the proble	em?		☐ Yes	□ No	Don't Know
		ess than 1 m		than 1 mo	onth 🗌	No Treat	tment Doe	s not app	ly Don't Know
	13. Can the patient walk normally?		1-3-			Yes	⊡ No		Don't Know
	14. Is there a known brain tumor?					Yes	□ No		Don't Know
	15. Has there been a known (not suspec	ted) recent st	troke or TIA?			Yes	□ No		Don't Know
	 Is there a family history of 1st degree 17. Is there previous MRI or CT head im 	relatives with	n a brain aneurys	m?		Yes Yes			Don't Know
	18. Has there been a recent evaluation b			on?		165	☐ No ☐ Yes	ΠNο	Don't Know
	Please check the appropriate box descri			rdering	Physicia	n			
Add Info		bing you.	🗌 F	acility Other	-				
	Please Sign and Date Below: Resp	onsible Con	tact:						
Signature	Print Name:				Da	ate:			
Sign	Sign Name:								

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PRI-SM

MRA/CTA Head & 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 (S	Same Day) RI	EQUEST	TS ARE AC	CEP	TED BY PH	ONE (ONLY A	AT (888) (693-3	3211.		
*	Patient F	First Name:				Patie	ent Last Name:	5						
Member Info	DOB:		Mbr ID:		Group	ρ#:				H	lealth	n Plan:		
Mei	Address:		1	(City:					s	ST:		Zip	
	Physiciar	n First Name:				Phy	sician Last Nar	me:			_	l		
		Specialty:			NPI:	<u> </u>				<u> </u>	Fax ID)-		
ian	,	. ,										·	-	
Physician Info	Address:	с		City	y:					5	ST:		Zip:	
h Ph	Phone #:			Fax #:			Conta	act Ema	iail:			·		
	Facility N	lame:				Faci	ility Tax ID:							
Facility Info	Address:			(City:						ST:		Zip:	
Fac Info	Phone #:		Fax	x #:			г	RE'	TRO D	ate of Serv	vice:	I		
	Please	circle all that apply:	CPT [®] Cod	e(s): C		704	-					• 70544	70545	70546
		ECK: 70547 70548				104	50 G IA		10400			. 100-0	10040	70040
	ICD-9:	Without	t Contrast		With Cor	ntrast	i		Without	and Wit	h Co	ntrast		
	1.				locumented	1 conf	lact with	Date	2			None	Do	n't Know
		physician: Date (f		/yyyy)							┼┍		┼┍──	
	2.	Type of most recent documented contact		L) Hospita	al Difficient		Phone c with office s			one call hysician		Email	Other	Don't Know
		physician?	A WIGH	поэрка	JI YISK	ļ	With Onice 5		marp	Tyoroida.			Ouro.	NION
8	3.	Is there previous he			roblem with	nin the		/ears?	? [Yes		No		on't Know
nati							Date:			Other		None		on't Know
Lo	5.	Has there been rec								Yes		No		on't Know
Clinical Information	6.	Is dementia or Alzh suspected?			Demen	itia	Alzhein	ners		Both		Neither		on't Know
nice	7.	Has there been a n	ew onset of e	pileptic	seizure?					Yes		No		on't Know
١ <u>ٿ</u>	8.	Is there a history of	migraines?						[Yes		No		on't Know
	9.	Has there been per treatment?	sistent unres	ponsive	vertigo des	spite s	several days	of		Yes		No		on't Know
	10.	Has a trial of physic	cian-directed	treatmer	nt been cor	nplete	ed?			Yes		No		on't Know
	11.	Has physician-direc problem?	ted treatmen:	t of at le	ast 3 week	s faile	ed to help the	2		Yes		No		on't Know
	12.	When did treatment	t start? 🔲 I	_ess tha	n 1 month a	ago			reatmen			🗌 Don't K	(now	
				/lore that	an 1 month a	ago		Does	not app					-4
		Can the patient wal							<u>_</u>	Yes		No		on't Know
		Is there a known brack Has there been a known brack		enected	\ recent str	oke o	r ⊤I∆2					No No		on't Know on't Know
		Is there a family his						,		Yes		No		on't Know
		Is there previous M						-		Yes		No		on't Know
		Has there been a re						?		Yes		No		on't Know
	Please	check the appropriate	e box describ	ing you:	Orde	ring	Physician	F	acility)ther			_
	Please	Sign and Date Belo	w: Respo	nsible C	ontact:									
an		-	-											
Signature	Print Na	ame:						Da	ite:					
Sig	Sign Na	ame:					C	MD	RN		🗌 F	PA 🗌 NP	, 🗌 от	HER
	4													



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.

ř	Patient First Name:			Patient Las	st Nam	e:					
Vlember Info	DOB: Mbr	ID:	Gr	oup #:			Hea	alth Pla	n:		
Men Info	Address:		City:				ST:		Zip		
	Physician First Name:			Physician l	_ast Na	ame:					
lan	Primary Specialty:		NPI:	-			Тах	ID:			
Physician Info	Address:		City:				ST:		Zip:		
두 je	Phone #:	Fax #:			Conta	act Email:	-1				
	Facility Name:			Facility Tax	k ID:						
cility	Address:		City:				S	T:	Zip:		
Fac	Phone #:	Fax #:				RETR	O Da	ate of S	Service:		
	ICD-9:	Please circle all							56		
	Without Contrast	(T-Spine) 72146		(L-Spine)	72140				Contrast		
	1. Date of most recent office		ented contac	t with				□ Non			n't Know
	physician: Date (format 2. Type of most recent docur		☐ Offi	ce Phone	Date_	Phone				_	Don't
	contact with physician?	Hospita				with physic		Emai	il Oth		Know
	What was the date of the pain, neck pain, etc.)?	-IRST office visit for t	this episode	of symptoms (ba	аск	first visit for t		Date			n't Know
	Date (format mm/dd/yyyy) 4. Is there previous imaging	for this problem withi	n the past 6	months?		episode		□ No			on't Know
	5. Is there a personal history					☐ Yes					on't Know
	 Has there been failure to i treatment? 			☐ 4 weeks or less	6] 8 or nore wk		No No] Don't now
tion	7. In the last two months, has the].]:						
Clinical Information	 A motor vehicle accident A fall from a height Other injury or trauma: 	(MVA) Any f	fall landing o ad trauma w	n the head rith loss of consci	iousnes	s □D	o injury on't Kn	or trau ow	ma		
8	8. Is the imaging request rela	ated to back or neck r	pain?			□ Yes		□ No] Don'	Know
lini		II that apply: CPT®		ARI: 70336 7	0540	70542 70543		0551 7	1 -	70553	
U	70450 70460 70470 70496	Other				[r	Yes		No [Don	t Kaaw
	 Is there previous head ima 10. Date of previous head ima 		i wiinin ine p	Date			Don'i			None	
	11. Has there been recent ons					Yes		No		Don	
	Is dementia or Alzheimer's] Dementia	Alzhe			🗌 Nei			't Know
	13. Has there been a new ons		e?			Yes		No			t Know
	14. Is there a history of migrai		1 3			Yes] No		Don	t Know on't Know
	 Has there been persistent Has a trial of physician-dire 				tment?	☐ Yes		es [[]No			t Know
	13. Has physician–directed tre				lem?		Yes				t Know
	14. When did treatment	Less than 1 mon				o Treatment		bes not			n't Know
	start? 15. Can the patient walk norm	ally2			<u> </u>	□ Yes		No		Don	t Know
	16. Is there a known brain tum					☐ Yes	╶┤╞	No			t Know
	Please check the appropri		ou: 🗌 Ord	ering Physician	🗆 Fa		Other				
	Please Sign and Date Below: Re			- /		. –	_			_	
Signature	Print Name:			Date:							
ign				_		LPN 🗆 PA			- THER		
0	Sign Name:										

LSUHSC Shreveport RUMS Reference



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.

	Patient First Name:			Patient Last N	ame:		
lber	DOB:	Mbr IDr:		Group #:			Health Plan:
Member Info	Address:		City:	I	ST:		Zip
ç	Physician First Name:			Physician L	.ast Name:		
Physician Information	Primary Specialty:		NPI:		Tax ID:		
iysid Torm	Address:		City:		ST:		Zip
두 F	Phone #:		Fax #:	Contact Email	:		
	Facility Name:			Tax ID:	1		
Facility Info	Address:		City:		ST:		Zip
Faci	Phone #:		Fax #:		RETRO Dat	e of Service:	
	ICD-9:	Please c	ircle all that apply:	CPT [®] Code(s):			
	Without Contrast		With Contrast			Without and Wit	n Contrast
	 Date of most recent of physician: Date (fermionic) 	fice visit or o ormat mm/dd			ate	□ None	Don't Know
	Type of most recent doc	umented con	tact with physician?	I			
	☐ Hospital ☐ Office visit		one call with office staf one call with physician	f ☐ Email ☐ Other	🗌 Don't Knov	v	
	3. Is there a reason to av				Yes	□ No	Don't Know
ы	Is there a current preg	nancy?			Yes	□ No	Don't Know
Clinical Information	5. Is this for right lower q	uadrant pain	with associated feve	r?	Yes	□ No	Don't Know
Info	Is this to evaluate cause	ses of hemat	uria?		Yes	□ No	Don't Know
inical	7. Is pain present?				Yes	□ No	Don't Know
G	Are there unclear findi	ng in previou	s CT-Pelvis imaging	?	Yes	□ No	Don't Know
	Is this for pre or post s	urgery evalu	ation?		Yes	□ No	Don't Know
	10. Is a UAE planned?				Yes	□ No	Don't Know
	11. Has a UAE been comp				Yes	□ No	Don't Know
	12. Is abnormal uterine or	vaginal blee	ding present?		Yes	□ No	Don't Know
	Has there been a period				Yes	No No	Don't Know
Add Info	Please check the appropri-	ate box desc	🗍 🗍 Fac	ering Physician ility er			
	Please Sign and Date Below:	Respo	nsible Contact:				
Signature	Print Name:				Date:		
Sigr	Sign Name:			N			

MEDSOLUTIONS

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.

	Patient First	st Name:					P	atient Las	st Nan	ne:						
lber	DOB:		Mbr ID:				Group #	ŧ				Hea	alth Plan:			
Member Info	Address:	dress: ysician First Name: mary Specialty: dress: one #: cility Name: dress: one #: D-9: Without Contrast D-9: Without Contrast D-9: Without Contrast D-9: Without Contrast D-9: Date of most recent of physician: Date (for D-1, Type of most recent of physician? Date (format mm/dd/y Lis there previous imag 5. Is there a personal his 6. Has there been failure physician directed tread 7. In the last two months, h □ A fail from a height				City:						ST:		Zip		
c	Physician F	First Name:					P	'hysician l	.ast N	lam	e:					
Physician Info	Primary Sp	ecialty:				NPI:						Тах	ID:			
fo	Address:				Ci	ty:						ST:		Zip:		
	Phone #:			Fax	#:				Cont	tact	Email:					
		me:					F	acility Ta	(ID:							
allity.	Address:					City:							T:	Zip:		
Fac	Phone #:			Fax #:							RETRO D	Date	e of Servi	ce:		
	ICD-9:										Spine) 72141 8 72149 721			156		
	Witho	ut Contrast			ith Contra					_	Without an			ast		
						ment	ed contac	ct with		Dat	e		None	[D	on't Know
u	physician: Date (fc 2. Type of most recent documented contact physician? 3. What was the date of				□ Hospital		Office visit	Pho with offi	ce sta	aff	Phone ca with physicia		□ Email	Oth	her	□ Don't Know
Clinical Information	th pa	is episode of sy ain, etc.)?	mptoms	(back pa		İ	☐ This is this episo ☐ Don't I		visit fo	or	Date			F	Free	Text:
8					roblem wi	thin t	he past si	ix months	?		Yes		No			on't Know
lini	5. Is	there a persona	al history	of cance	er other th	an or	dinary sk	in cancer	?		☐ Yes		No	1	 _ D	on't Know
0	p	nysician directed	l treatme	ent?			or less	s 🗆 6			B weeks or more] No reatment		D	on't Know
		A motor vehicle	accident ght		🗋 Ar	ny fall	landing of		ad				No injury Don't Kno		auma	l
	8. Is	the imaging req	uest rela	ated to ba	ack or nec	:k pai	n?				Yes] No	[D	on't Know
Add Info	Please che	eck the appropria	ate box d	lescribino	g you:		- Eac	dering Phy cility her	-		-					
	Please Sig	gn and Date Be	low:	Respons	ible Conta	act:										
Signature		e:		•)ate	:					
Sign																
	Sign Nam	e:						[MD		RN 🗌 LPN	P			от	HER

		COST MANAGEMENT In some case MedSolutions Fax requests	f this form is the s, more clinical i reserves the rig (non urgent requ	ear Imag minimum require information is req ght to request det uests only) to Me JESTS ARE ACC	ed informa uired. ailed info dSolutior	ation to start rmation for th ns (888) 693-	a case. ne patient. 3210.	(888) 69:	PRI-SM 3-3211.
5	Patient Firs	Name:				Patient La	st Name:		
mau	DOB:	Mb	r ID:			Group #			Health Plan:
Information	Address:		City:			ST			Zip:
	Physician F	irst Name:				Physician	Last Nam	ie:	
lion	Primary Spe	ecialty:	NPI:			Tax ID:			
Information	Address:		City:			ST			Zip:
Ĕ	Phone #:		Fax #:			Contact Er	mail:		I
-	Facility Nan	ne:				Facility Ta	x ID:		
Information	Address:	City:				ST		Zip:	
UIOIU	Phone #:	Fax #:					Date of	Service	
	ICD-9:	Please circle all that apply: C	PT [®] Code(s):	78465 78478 78	3480 78				3 78469 78472 78473
		78481 78483 78494 78496 784	99 OTHER						
		of most recent office visit or other of days or less	locumented con Nore than 30 da		In?		mat mm/do Don't I		
		of most recent documented contac	t with physician Phone call with c	?	□ Emai	i	Don't ł	(00)	
	O	fice visit 🗌 🛙	Phone call with p		Othe	r	_		
		e symptoms present? ymptoms are present, are the sym	ntomo woroonin	~?	Yes Yes			t Know t Know	Does not apply
		s an EKG been performed?	ptoms worsening	41	☐ Yes			t Know	Does not apply
		at was the date of the most recent	EKG? Date (fo	rmat mm/dd/yyyy				t Know	No EKG performed
	7. lst ⊡No	he EKG Normal or Abnormal? ormal Don't Know					VC Dorform	and	
		n exercise on a treadmill be perfor		Abnormal	Yes		KG Perforr Don'		
	9. Wr	at is the resting heart rate? Be	ats/Min (I	Please enter a nu				_ Don't	
	10. Wr	at was the most recent blood pres	sure? Systolic_ Diastolic			number betv number betv			Don't Know
	11. ls t	here a history of hypertension?	Diastone	(11040)	Yes		Don'		
	12. ls t	here a lifetime history of smoking of	of 5 years or mo	re?	Yes	🗆 No	🗌 Don'	t Know	
	13. ls (liabetes present?			Yes	🗌 No	🗌 Don'	t Know	
	14. ls t	here a history of high cholesterol?			Yes	No	🗌 Don'	t Know	
		here a history of peripheral vascul			Yes	No	🗌 Don'	t Know	
		s there been any heart testing (oth	er than EKG) wi	thin the past two				No	Don't Know
		here a history of bypass surgery?	D-1	/f	Yes	□ No	Don'	t Know	
		ter date of most recent bypass sur Five years ago or less	gery: Date ☐ More than 5	e (format mm/dd/y vears ago	yyyy) ∟ ∏Don't)ate t Know	□ No b	pass su	rgery done
	19. Wł	at other heart procedures have be		Angioplasty (🗆 Cardia		
		Pacemaker Other: er heart procedure (Free Text):		None	L	Don't Know	/	9	Don't Know
	20. En	ter date of most recent Angioplasty				Date (format	mm/dd/yyy	/y) Dat	
		Five years ago or less IN eight as measured in Pounds (Ibs):			Oon't Kno enter a n	w umber betw	lo procedu een 1 and		Don't Know
		ight as measured in Feet (ft) and li	nches (in) : Heig	ht (ft) (l	Please er	nter a numbe	er between	1 and 8)	Don't Know
	DI 1					enter a numb	er between	n 0 and 9	6)
	Please chec	k the appropriate box describinç		Ordering Phys Facility	lician				
	Blassa Cirr	and Data Balawy		Other Other					
	riease sigi	n and Date Below:	Responsi	ne contact.					
	Print Name	:		Date	£				