MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

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

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. 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: ____________________

Question			
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___________

Question					
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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