MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

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: 72-0702002	
Address: 1501 Kings Highway	City: Shreveport	ST: LA	Zip: 71130-3932
Phone #: 318-675-7074	Fax #:	Contact Email:	

Facility Info

Facility Name: LSU Health Sciences Center		Tax ID: 72-07020002	
Address: 1501 Kings Highway	City: Shreveport	ST: LA	Zip: 71130-3932
Phone #: 318-675-7074	Fax #: see bottom of page	☐ 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: Name of Attending Physician_____

Print Name: _____ **Date:** _____

Sign Name: _____ ☐ **MD** ☐ **RN** ☐ **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.

Fax# For Approvals 318-675-6212 For Denials 318-675-7073

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