MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

PRI-SM

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: 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		Facility Tax ID: 72-0702002	
Address: 1501 Kings Highway	City: Shreveport	ST: LA	Zip: 7110dd
Phone #: 318-675-7074	Fax #: see bottom of page	☐ RETRO Date of Service:	

Clinical Information

ICD-9:

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

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy) — Date_____ ☐ None ☐ Don't Know

2. Type of most recent documented contact with physician? ☐ Hospital ☐ Office visit ☐ Phone call with office staff ☐ Phone call with physician ☐ Email ☐ Other ☐ Don't Know

3. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)? Date (format mm/dd/yyyy) — ☐ This is the first visit for this episode ☐ Don't Know — Date_____ Free Text:

4. Is there previous imaging for this problem within the past six months? ☐ Yes ☐ No ☐ Don't Know

5. Is there a personal history of cancer other than ordinary skin cancer? ☐ Yes ☐ No ☐ Don't Know

6. Has there been failure to improve with physician directed treatment? ☐ 4 weeks or less ☐ 6 weeks ☐ 8 weeks or more ☐ No Treatment ☐ Don't Know

7. In the last two months, has there been significant trauma to the spine involving:
☐ A motor vehicle accident (MVA) ☐ Any fall landing on the head ☐ No injury or trauma
☐ A fall from a height ☐ A head trauma with loss of consciousness ☐ Don't Know
☐ Other injury or trauma: _____

8. Is the imaging request related to back or neck pain? ☐ Yes ☐ No ☐ Don't Know

Add Info

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

Signature

Please Sign and Date Below: Responsible Contact: Name of Attending Physician _____

Print Name: _____ **Date:** _____

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

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