MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI Abdomen & Pelvis Imaging Request

Completing this survey can provide quicker turnaround. Additional comments can be made in the comments section. We encourage you to electronically forward relevant data/notes, especially results of previous imaging or testing. This form and all data submitted are legally considered an extension of the medical record with regard to privacy and accuracy. Any inconsistencies on this survey compared with the office medical record should be explained in the comments section. MedSolutions reserves the right to request detailed information for the patient. Fax forms *(non-urgent requests only)* to **888.693.3210.**

URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.

Member

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

Physician

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

Facility

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

Clinical

Check all applicable CPT® code(s) (REQUIRED): MRI Abdomen: ☐ 74181 ☐ 74182 ☐ 74183
MRI PELVIS: ☐ 72195 ☐ 72196 ☐ 72197 ☐ Other:_____

ICD-9 Code (s) (REQUIRED):

1. Date of most recent office visit or other documented contact with physician:

   Date: _____ (mm/dd/yyyy) ☐ None ☐ Don't Know

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

3. Is there a reason to avoid CT contrast (allergy to contrast material or renal failure)?
   ☐ Yes ☐ No ☐ Don't Know

4. Is a lipoma suspected?
   ☐ Yes ☐ No ☐ Don't Know

5. Are there unclear findings on pervious ultrasound?
   ☐ Yes ☐ No ☐ Don't Know

6. Is there a current pregnancy?
   ☐ Yes ☐ No ☐ Don't Know

7. Is this for right lower quadrant pain with associated fever?
   ☐ Yes ☐ No ☐ Don't Know

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8. Is this to evaluate for causes of hematura?
☐ Yes ☐ No ☐ Don't Know

9. Is pain present?
☐ Yes ☐ No ☐ Don't Know

10. Are there unclear findings in previous CT-**Abdomen** imaging?
☐ Yes ☐ No ☐ Don't Know

11. Is this for right upper quadrant pain associated with fever?
☐ Yes ☐ No ☐ Don't know

12. Is jaundice present?
☐ Yes ☐ No ☐ Don't Know

13. Is the AFP elevated?
☐ Yes ☐ No ☐ Don't Know

14. Is the study to evaluate liver lesion?
☐ Yes ☐ No ☐ Don't Know

15. Are there unclear findings in previous CT-**Pelvic** imaging?
☐ Yes ☐ No ☐ Don't Know

16. Is this for pre or post surgery?
☐ Yes ☐ No ☐ Don't Know

17. Is a UAE planned? (Uterine Artery Embolization (UAE)- Is an invasive procedure to treat fibroids)
☐ Yes ☐ No ☐ Don't Know

18. Has a UAE been completed within the last 6 months? (Uterine Artery Embolization (UAE)- Is an invasive procedure to treat fibroids)
☐ Yes ☐ No ☐ Don't Know

19. Is abnormal uterine or vaginal bleeding present?
☐ Yes ☐ No ☐ Don't know

20. Has there been a period of conservative treatment (Birth control pills or Hormones)?
☐ Yes ☐ No ☐ Don't Know

Who will be the responsible contact for additional information, if requested, or questions concerning this request?

Print Name:_____

Additional Information/Comments:

Submitter

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

Sign and Date Below:

Responsible Contact: _____

Print Name:_____

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