MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI Spine – Multiple Sclerosis 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. 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 circle all applicable CPT® code(s): MRI C-Spine :☐ 72141 ☐ 72142 ☐ 72156 **MRI T-Spine**: ☐ 72146 ☐ 72147 ☐ 72157 **MRI L-Spine** ☐ 72148 ☐ 72149 ☐ 72158 ☐ Other: _____

ICD-9 Code (Required Field):

1. Is this request to rule out or evaluate any of the following? Please choose **only** the primary reason.
   - ☐ Back/neck pain (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back pain fax form)
   - ☐ Multiple Sclerosis
   - ☐ Known or suspected spine trauma (This is the incorrect fax form. Please use MRI Spine – trauma fax form)
   - ☐ Metastatic cancer (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back pain fax form)
   - ☐ Surgical planning/Pre-op (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back pain fax form)
   - ☐ None of the above (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back pain fax form)
   - ☐ Don't know (This is the incorrect fax form. Please use MRI Spine – Evaluate Neck/Back pain fax form)

2. Provide the following dates:
   - ☐ Date of the first office visit with any physician for this episode (mm/dd/yyyy) _____
   - ☐ Date of the most recent office visit for this episode (mm/dd/yyyy) _____
   - ☐ Don't Know

3. Is this request for suspected or confirmed (established) MS?
   - ☐ Suspected
   - ☐ Established
   - ☐ Don't know

4. If MS is a confirmed (established) diagnosis, is immunotherapy currently being used? *(Hint- immunotherapy may consist of : Copaxone®, Tysabri®, Novantrone® or beta-interferons such as Avonex® , Betaseron® or Rebif®)*
   - ☐ No, this is for suspected MS
   - ☐ Confirmed MS with use of immunotherapy
   - ☐ Confirmed MS, not currently using immunotherapy ☐ Don't know

5. Have any of the following neurological deficits occurred in the past month? (choose all that apply)

- ☐ Sensory problems *(Hint- loss of function or sensation to one side of the body, tingling or shooting pain)*
- ☐ Bowel or bladder problems
- ☐ Hemiparesis *(Hint- [*hem-ee-p*uh-**ree**-sis]muscular weakness of one half of the body)*
- ☐ Gait or balance problems *(Hint- Gait refers to the way or style of walking)*
- ☐ Vision disturbances *(Hint- double vision, loss of vision, etc.)*
- ☐ Other : _____
- ☐ Don't know

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

Print Name:_____

Additional Information/Comments:

Submitter

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

Sign and Date Below:

Print Name:_____

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