MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI and CT Head & CT Neck 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 tests. 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): CT NECK ☐ 70490 ☐ 70491 ☐ 70492 **MRI HEAD:** ☐ 70336 ☐ 70540 ☐ 70542 ☐ 70543 ☐ 70551 ☐ 70552 ☐ 7055**3** **CT HEAD:** ☐ 70450 ☐ 70460 ☐ 70470 ☐ 70496
☐ **Other**_____

ICD-9 Code (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 this test to image the spine?
   ☐ Yes ☐ No ☐ Don't Know
4. Is cancer suspected?
   ☐ Suspected, not confirmed ☐ Known History ☐ Not Suspected ☐ Don't Know
5. Is there a neck mass?
   ☐ Yes ☐ No ☐ Don't Know
6. Is the neck mass painful?
   ☐ Yes ☐ No ☐ Don't Know
7. Has there been difficulty or pain with swallowing?
   ☐ Yes ☐ No ☐ Don't Know
8. Is a thyroid problem suspected?
   ☐ Yes ☐ No ☐ Don't Know

9. Has a neck ultrasound been:
☐ Done ☐ Planned ☐ Neither ☐ Don't Know

10. Is neck surgery planned?
☐ Yes ☐ No ☐ Don't Know

11. Is there previous head imaging for this problem within the past three years?
☐ Yes ☐ No ☐ Know

12. Date of previous head imaging?
☐ Date _____ ☐ None ☐ Don't Know ☐ Other_____

13. Has there been recent onset of hemiplegia?
☐ Yes ☐ No ☐ Don't Know

14. Is Dementia or Alzheimer's disease suspected?
☐ Dementia
☐ Alzheimer's
☐ Both
☐ Neither
☐ Don't Know

15. Has there been a new onset of epileptic seizure?
☐ Yes ☐ No ☐ Don't Know

16. Is there a history of migraines?
☐ Yes ☐ No ☐ Don't Know

17. Has there been persistent unresponsive vertigo despite several days of treatment?
☐ Yes ☐ No ☐ Don't Know

18. Has a trial of physician-directed treatment been completed?
☐ Yes ☐ No ☐ Don't Know

19. Has physician-directed treatment of at least 3 weeks failed to help the problem?
☐ Yes ☐ No ☐ Don't Know

20. When did treatment start?
☐ Less than 1 month ago
☐ More than 1 month ago
☐ No Treatment
☐ Does not apply
☐ Don't Know

21. Can the patient walk normally?
☐ Yes ☐ No ☐ Don't Know

22. Is there a known brain tumor?
☐ 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:

Print Name:_____

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