MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI and CT Head & MRI Spine 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): C-Spine: ☐ 72141 ☐ 72142 ☐ 72156 **T-Spine**: ☐ 72146 ☐ 72147 ☐ 72157 **L-Spine**: ☐ 72148 ☐ 72149 ☐ 72158 **MRI HEAD:** ☐ 70551 ☐ 70552 ☐ 70553 **CT HEAD:** ☐ 70450 ☐ 70460 ☐ 70470 ☐ 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. What was the date of the FIRST office visit for this episode of symptoms (back pain, neck pain, etc.)?
   - ☐ This is the first visit for this episode
   - ☐ Date _____
   - ☐ Don't Know
4. Is there a previous imaging for this problem within the past 6 months?
   ☐ Suspected, not confirmed ☐ Known History ☐ Not Suspected ☐ 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 a failure to improve with physician directed treatment?
   - ☐ 4 weeks or less
   - ☐ 6 weeks
   - ☐ 8 or more weeks
   - ☐ 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
   - ☐ A fall from a height
   - ☐ A head trauma with loss of consciousness
   - ☐ No injury or trauma
   - ☐ Other injury or trauma_____
   - ☐ Don't Know

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

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

10. Date of previous head imaging?
    - ☐ Date _____
    - ☐ Don't Know
    - ☐ Other
    - ☐ None

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

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

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

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

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

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

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

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

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

20. 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**