MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

ONCOLOGY CT- MR FAX FORM

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

Please note that this form is for CT/MR Oncology imaging requests only.

If this request is for a PET or a PET/CT, please use the appropriate PET-CT form available on the portal.

List all CPT® code(s) (Required Field):

ICD-9 Code (Required Field):

Please fill in the following questions; non-applicable questions may be skipped.

1. Date of the most recent office visit or other documented contact with physician (mm/dd/yyyy) _____
   - ☐ Don't Know

2. Has cancer diagnosis been confirmed by biopsy?
   - ☐ Yes Date of biopsy which confirmed THIS diagnosis (mm/dd/yyyy) _____
   - ☐ No
   - ☐ Don't Know

3. What is the cell type and location of primary disease?
   - Cell type: _____
   - Location: _____
   - ☐ Unknown primary

4. If cancer was recently diagnosed, size of primary tumor

_____

☐ Don't know

5. Is there known metastatic disease? (Metastatic disease = tumor cells have spread to other parts of the body)

☐ Yes
☐ No
☐ Don't know

6. Please choose the correct response in regards to resection of this cancer.

☐ Resection not appropriate or is not feasible
☐ Resection was done and removed all known tumor
☐ Resection did not remove all known tumor
☐ Resection is planned following this imaging
☐ Don't know.

7. Is this a recurrent disease?

☐ No, this is not a recurrence
☐ Yes, Date of THIS recurrence (mm/dd/yyyy) _____
☐ Don't know

8. Was the individual recently (within last 3 months) treated with chemotherapy and/or is chemotherapy planned soon? (**Choose all that apply**)

☐ No chemotherapy in last 3 months
☐ Chemo is currently on-going
☐ Chemotherapy completed within the last 3 months
☐ Chemotherapy is planned
☐ Don't know.

9. Has a course of radiation therapy been completed or is planned?

☐ No radiation
☐ Radiation finished less than 90 days ago
☐ Radiation finished more than 90 days ago
☐ Radiation is planned in the future
☐ Radiation is on-going
☐ Don't know

10. Is a tumor marker (PSA, CEA, etc.) test elevated with documented rising from the previous level?

☐ No
☐ Yes
☐ Don't know

11. Currently, are there new signs or symptoms suggesting progression of disease?

☐ Yes, symptoms are worrisome for progression of disease
☐ Yes, there are objective signs on the physical examination
☐ Yes, there are both signs and symptoms
☐ No, there are no current signs or symptoms
☐ Don't Know

12. Is the requested study for the evaluation of abnormalities seen on previous imaging?

☐ No

☐ Yes (please provide date and type of previous imaging)

Date of previous imaging (mm/dd/yyyy) _____

Type of previous imaging (US, CT, MRI, etc.) _____

☐ Don't Know

Who will be the responsible contact for additional information, if needed, 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**