MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI Spine - FAX – Known or Suspected Spine Trauma

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 *(This is the incorrect fax form. Please use **MRI Spine - Multiple Sclerosis** fax form)*

☐Known or suspected spine trauma

☐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)*

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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. Has there been a history of spine trauma from any of the following?

☐ No injury or trauma
☐ Motor Vehicle Accident (MVA)
☐ Fall from height over 3 feet or 5 stairs
☐ Head trauma with loss of consciousness
☐ Diving accident (*hover hint: Diving board, cliff diving, etc.)*
☐ Strain from lifting, turning head, minor fall
☐ None of the above
☐ Don't know

4. When did the spine trauma occur?

☐ No injury or trauma
☐ Less than a month ago
☐ One to three months ago
☐ Greater than three months ago
☐ Don't know

5. What are the current symptoms? (Choose all that apply)

☐ No symptoms
☐ Lower back pain
☐ Hip or thigh pain
☐ Leg pain that goes below the knee
☐ Neck pain
☐ Upper back pain *(hover hint: middle or upper* back)
☐ Arm pain that goes into forearm or hand
☐ None of the above
☐ Don't know

6. How long has there been physician-directed treatment or observation since the onset of this episode? *(hover hint: Physician directed treatment might include the following: pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program)*

☐ No physician directed treatment
☐ Three weeks or fewer
☐ Four weeks
☐ Five weeks
☐ Six weeks
☐ Seven weeks
☐ Eight weeks or more
☐ Don't Know

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7. How have symptoms changed with physician directed treatment or observation? *(hover hint: Physician directed treatment might include the following: pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program.)*

- ☐ No physician directed treatment or observation
- ☐ Symptoms have improved
- ☐ Symptoms have stayed the same
- ☐ Symptoms have worsened
- ☐ Don't know

8. Were any of the following found on a physical exam performed for this episode? (Choose all that apply)

- ☐ No physical exam performed
- ☐ Weakness in extremity(ies) on exam *(hover hint: not patient reported weakness)*
- ☐ Upper motor neuron signs (*hover hint: Hoffman's, Babinski, Hyperreflexia)*
- ☐ None of the above
- ☐ Don't Know

9. Has a CT or MRI of the cervical spine been performed since the initial spine trauma?

- ☐ No CT or MRI of the cervical spine has been performed
- ☐ Cervical spine CT
- ☐ Cervical spine MRI
- ☐ None of the above
- ☐ 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**

CLICK HERE TO RETURN TO MAIN MENU