MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI Spine - FAX – Evaluate Neck/Back pain

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
   - ☐Multiple Sclerosis *(This is the incorrect fax form. Please use **MRI Spine - Multiple Sclerosis** fax form)*
   - ☐Known or suspected spine trauma *(This is the incorrect fax form. Please use **MRI Spine – Trauma** fax form)*
   - ☐Metastatic cancer
   - ☐Surgical planning/Pre-op
   - ☐ None of the above *(Please enter reason in the comment section at the end of the survey.)*
   - ☐Don't know

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

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3. 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

4. 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

5. 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

6. 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)*
- ☐ Limited range of motion
- ☐ Foot drop
- ☐ Upper motor neuron signs (*hover hint: Hoffman's, Babinski, Hyperreflexia)*
- ☐ Incontinence of bowel/bladder
- ☐ Trouble walking on heels or toes
- ☐ None of the above
- ☐ Don't Know

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7. Are any of the following present in the medical history? (Choose all that apply)

☐ Cancer that has been treated within the last ten years other than squamous (skwā-məs) or basal (bā-səl) cell skin cancer
☐ Back surgery or cervical spine surgery
☐ Immunosuppression *(hover hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis)*
☐ IV drug use
☐ None of the above
☐ Don't Know

8. Has a CT or MRI of the cervical spine been performed within the last six months?

☐ Yes ☐ No ☐ Don't know

9. Has a CT or MRI of the thoracic spine been performed within the last six months?

☐ Yes ☐ No ☐ Don't know

10. Has a CT or MRI of the lumbar spine been performed within the last six months?

☐ Yes ☐ No ☐ 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:

Responsible Contact: _____

Print Name:_____

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

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INTELLIGENT COST MANAGEMENT

MRI Spine - FAX – Known or Suspected Spine Trauma

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Member

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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

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ICD-9 Code (Required Field): _____

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☐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)*

MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

MRI Spine FAX – Multiple Sclerosis

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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

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☐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)*

MED SOLUTIONS
INTELLIGENT COST MANAGEMENT

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? *(Hover 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 (Hover hint- loss of function or sensation to one side of the body, tingling or shooting pain)
- ☐ Bowel or bladder problems
- ☐ Hemiparesis (Hover hint- [hem-ee-p*uh*-**ree**-sis]muscular weakness of one half of the body)
- ☐ Gait or balance problems (Hover hint- Gait refers to the way or style of walking)
- ☐ Vision disturbances (Hover hint- double vision, loss of vision, etc.)
- ☐ Other : Free Text
- ☐ 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**

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