

**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.**

<b>Member</b>	Patient First Name:		Patient Last Name:			
	DOB:	Member ID:	Group #:		Health Plan:	
	Address:		City:		ST:	Zip:
<b>Physician</b>	Physician First Name:		Physician Last Name:			
	Primary Specialty:		NPI:		Tax ID:	
	Address:		City:		ST:	Zip:
	Phone #:	Fax #:	Contact Email:			
<b>Facility</b>	Facility Name:		Facility Tax ID:			
	Address:		City:		ST:	Zip:
	Phone #:	Fax #:	NPI:	<input type="checkbox"/> RETRO Date of Service:		
<b>Clinical</b>	<b>Check circle all applicable CPT® code(s):</b> MRI C-Spine : <input type="checkbox"/> 72141 <input type="checkbox"/> 72142 <input type="checkbox"/> 72156 MRI T-Spine: <input type="checkbox"/> 72146 <input type="checkbox"/> 72147 <input type="checkbox"/> 72157 MRI L-Spine <input type="checkbox"/> 72148 <input type="checkbox"/> 72149 <input type="checkbox"/> 72158 <input type="checkbox"/> Other: _____					
	<b>ICD-9 Code (Required Field):</b> _____					
	1. Is this request to rule out or evaluate any of the following? Please choose <b>only</b> the primary reason. <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Multiple Sclerosis ( <i>This is the incorrect fax form. Please use <b>MRI Spine - Multiple Sclerosis fax form</b></i> ) <input type="checkbox"/> Known or suspected spine trauma ( <i>This is the incorrect fax form. Please use <b>MRI Spine – Trauma fax form</b></i> ) <input type="checkbox"/> Metastatic cancer <input checked="" type="checkbox"/> Surgical planning/Pre-op <input type="checkbox"/> None of the above ( <i>Please enter reason in the comment section at the end of the survey.</i> ) <input type="checkbox"/> Don't know					
2. Provide the following dates: <input type="checkbox"/> Date of the first office visit with any physician for this episode (mm/dd/yyyy) _____ <input type="checkbox"/> Date of the most recent office visit for this episode (mm/dd/yyyy) _____ <input type="checkbox"/> Don't Know						

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

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-mēs) 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:**

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

Submitter

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**MRI Spine - FAX – Known or Suspected Spine Trauma**

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<b>Member</b>	Patient First Name:		Patient Last Name:		
	DOB:	Member ID:	Group #:	Health Plan:	
	Address:		City:	ST:	Zip:
<b>Physician</b>	Physician First Name:		Physician Last Name:		
	Primary Specialty:	NPI:	Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:		
<b>Facility</b>	Facility Name:		Facility Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	NPI:	<input type="checkbox"/> RETRO Date of Service:	
<b>Clinical</b>	<b>Check circle all applicable CPT® code(s):</b> MRI C-Spine : <input type="checkbox"/> 72141 <input type="checkbox"/> 72142 <input type="checkbox"/> 72156   MRI T-Spine: <input type="checkbox"/> 72146 <input type="checkbox"/> 72147 <input type="checkbox"/> 72157   MRI L-Spine <input type="checkbox"/> 72148 <input type="checkbox"/> 72149 <input type="checkbox"/> 72158 <input type="checkbox"/> Other: _____				
	<b>ICD-9 Code (Required Field):</b> _____				
	1. Is this request to rule out or evaluate any of the following? Please choose <b>only</b> the primary reason. <ul style="list-style-type: none"> <li><input type="checkbox"/> Back/neck pain (<i>This is the incorrect fax form. Please use <b>MRI Spine – Evaluate Neck/Back pain fax form</b></i>)</li> <li><input type="checkbox"/> Multiple Sclerosis (<i>This is the incorrect fax form. Please use <b>MRI Spine - Multiple Sclerosis fax form</b></i>)</li> <li><input type="checkbox"/> Known or suspected spine trauma</li> <li><input type="checkbox"/> Metastatic cancer (<i>This is the incorrect fax form. Please use <b>MRI Spine – Evaluate Neck/Back pain fax form</b></i>)</li> <li><input type="checkbox"/> Surgical planning/Pre-op (<i>This is the incorrect fax form. Please use <b>MRI Spine – Evaluate Neck/Back pain fax form</b></i>)</li> <li><input type="checkbox"/> None of the above (<i>This is the incorrect fax form. Please use <b>MRI Spine – Evaluate Neck/Back pain fax form</b></i>)</li> <li><input type="checkbox"/> Don't know (<i>This is the incorrect fax form. Please use <b>MRI Spine – Evaluate Neck/Back pain fax form</b></i>)</li> </ul>				

**MRI Spine FAX – Multiple Sclerosis**

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**URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.**

<b>Member</b>	Patient First Name:		Patient Last Name:		
	DOB:	Member ID:	Group #:	Health Plan:	
	Address:		City:	ST:	Zip:

<b>Physician</b>	Physician First Name:		Physician Last Name:		
	Primary Specialty:	NPI:	Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:		

<b>Facility</b>	Facility Name:		Facility Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	NPI:	<input type="checkbox"/> RETRO Date of Service:	

<b>Clinical</b>	<b>Check circle all applicable CPT® code(s):</b> MRI C-Spine : <input type="checkbox"/> 72141 <input type="checkbox"/> 72142 <input type="checkbox"/> 72156   MRI T-Spine: <input type="checkbox"/> 72146 <input type="checkbox"/> 72147 <input type="checkbox"/> 72157   MRI L-Spine <input type="checkbox"/> 72148 <input type="checkbox"/> 72149 <input type="checkbox"/> 72158 <input type="checkbox"/> Other: _____				
	<b>ICD-9 Code (Required Field):</b> _____				

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
  - Known or suspected spine trauma (*This is the incorrect fax form. Please use **MRI Spine – Known or Suspected Spine trauma** fax form*)
  - 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*)

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-puh-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:**

Check the appropriate box describing you:  Ordering Physician  Facility  Other

**Sign and Date Below:**

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

MD  RN  LPN  PA  NP  Other

Submitter

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