MEDSOLUTIONS
INTELLIGENT COST MANAGEMENT

PRI-SM

MRI LE & UE Joint Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Info

Patient First Name:		Patient Last Name:	
DOB:	Mbr ID:	Group #	Health Plan:
Address:	City:	ST:	Zip

Physician Information

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

Facility Info

Facility Name:		Facility Tax ID:	
Address:	City:	ST:	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:	

Clinical Information

ICD-9: **Please circle all that apply: CPT®** Code(s): **MRI UE JOINT:** 73221 73222 73223 **MRI LE JOINT:** 73721 73722 73723 OTHER_____

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

1. Date of most recent office visit or other documented contact with physician: Date (format mm/dd/yyyy)	Date_____	☐ None	☐ Don't Know

2. Type of most recent documented contact with physician?
☐ Hospital ☐ Phone call with office staff ☐ Email ☐ Don't Know
☐ Office visit ☐ Phone call with physician ☐ Other

3. What was the date of the FIRST office visit for this episode of symptoms (shoulder pain, knee pain, etc.)? Date (format mm/dd/yyyy)	Date_____	☐ This is the first visit for this episode ☐ Don't Know	Free text: _____ _____

4. Has a specialist evaluation been completed?	☐ Yes	☐ No	☐ Don't Know
5. Has there been a recent injury?	☐ Yes	☐ No	☐ Don't Know
6. Has an X-Ray been done?	☐ Yes	☐ No	☐ Don't Know
7. Is there a PERSONAL history of cancer other than ordinary skin cancer?	☐ Yes	☐ No	☐ Don't Know
8. Is this study to evaluate arthritis?	☐ Yes	☐ No	☐ Don't Know

9. What is the range of motion?	☐ Full Motion		☐ Limited/ Painful			☐ Don't Know
10. Has there been a period of conservative treatment?	☐ 3 weeks or less	☐ 4 weeks	☐ 6 weeks	☐ 8 weeks or more	☐ No treatment	☐ Don't Know

Add Info

Please check the appropriate box describing you:
☐ Ordering Physician
☐ Facility
☐ Other _____

Signature

Please Sign and Date Below: Responsible Contact:

Print Name: _____ **Date:** _____

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