

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.

uo.	Patient First Name:					Patient Last Name:						
Member Information	DOB: Mbr ID:				Group #			Health Plan:				
Mei Info	Address:			City:	City:			ST			Zip	
Physician trion Information	Physician First Name:				Physician Last Name:							
	Primary Specialty:				NPI:				Tax ID:			
	Address:			City:	City:			ST			Zip:	
	Phone #: Fax #:				Contact Email:				ail:			
	Facility Name:				Facility Tax ID:							
	Address:			City:				ST		Г	Zip:	
Facility Information	Phone #: Fax #:			_1			RETRO Date of Service:					
Fa In	ICD-9: Please circle one: CPT <sup>®</sup> Code(s): MRI UE JOINT: 73221 73222 73223 MRI LE JOINT: 73721 73722 73723										2 73723	
	Without Contrast With Contrast				rast			Without and With Contrast				
Clinical Information	1. Has a specialist evaluation been completed?							Yes		🗌 No	Don't Know	
	<ol> <li>Has there been a recent injury?</li> <li>Has an X-Ray been done?</li> </ol>									No No	Don't Know	
	<ol> <li>Does the patient have a history of cancer other than of</li> </ol>					dinany skin				No No	Don't Know	
	cancer?					Yes		s	□ No	Don't Know		
	5. Is this study to evaluate arthritis?					🗌 Yes			S	🗌 No	Don't Know	
	6. What is the range of motion?							Full Motion		Limited Painful	Don't Know	
	<ol> <li>Has the patient had conservative treatment? Physical therapy, medication or rest</li> </ol>			3 wee or le		4 weeks	☐ 6 weeks	6	8 weeks or more	None	Don't Know	
	8. Please check the appropriate box describing y				j you:			Ordering Physician		Facility	Other	
	<ol><li>Does the ordering physician have an ownership sta lease agreement covering the imaging requested w facility?</li></ol>							Yes		□ No	Don't Know	
	Please Sign and Date Below:											
Signature	Responsible Contact:           Print Name:         Date:											
Sig	Sign Name:											

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