MedSolutions
THE LEADER IN RADIOLOGY MANAGEMENT SOLUTIONS

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 Information

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 Information

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

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

☐ Without Contrast ☐ With Contrast ☐ Without and With Contrast

Clinical Information

1.	Has a specialist evaluation been completed?				☐ Yes	☐ No ☐ Don't Know
2.	Has there been a recent injury?				☐ Yes	☐ No ☐ Don't Know
3.	Has an X-Ray been done?				☐ Yes	☐ No ☐ Don't Know
4.	Does the patient have a history of cancer other than ordinary skin cancer?				☐ Yes	☐ No ☐ Don't Know
5.	Is this study to evaluate arthritis?				☐ Yes	☐ No ☐ Don't Know
6.	What is the range of motion?				☐ Full Motion	☐ Limited Painful ☐ Don't Know
7.	Has the patient had conservative treatment? Physical therapy, medication or rest	☐ 3 weeks or less	☐ 4 weeks	☐ 6 weeks	☐ 8 weeks or more	☐ None ☐ Don't Know
8.	Please check the appropriate box describing you:				☐ Ordering Physician	☐ Facility ☐ Other _____
9.	Does the ordering physician have an ownership stake, management or lease agreement covering the imaging requested with the rendering facility?				☐ Yes	☐ No ☐ Don't Know

Signature

Please Sign and Date Below:

Responsible Contact:

Print Name: _____ **Date:** _____

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