

UNIVERSAL REQUEST FORM
 Fax Request to MedSolutions at (888) 693-3210

Patient Name: _____ DOB: _____ Member ID#: _____
 Patient Home Telephone #: _____ Patient Work Telephone #: _____
 Group #: _____ Health Plan and State: _____ Specialist Referral #: _____
 Physician Requesting Exam (first/last names): _____ Physician Specialty: _____
 Tel # Physician Office (w area code): _____ Office Contact Person: _____
 Fax # Physician Office (w area code): _____ Date Request Submitted: _____
 Preferred Facility and location for Procedure: _____ MVA Workers Comp
 Is there a clinical reason this Facility must be used? _____

I would like MedSolutions to schedule this appointment Please send info on Scheduling Services
 Preferred Appointment Deadline: _____ Is this urgent or an emergency procedure? Yes
 Patient Appointment Preference (optional): Day/Date: _____ Time: _____
 Please schedule first available appointment Please contact Patient for appointment times

Working Diagnosis/ICD9 code: _____

➔ This form must be accompanied by medical notes/previous imaging reports that support the medical necessity for the study requested. Please check the procedure(s) being requested:

- | | |
|--------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> CT Head | <input type="checkbox"/> MRI Brain |
| <input type="checkbox"/> CT Orbit, Sella, Ear | <input type="checkbox"/> MRI Temporomandibular Joint |
| <input type="checkbox"/> CT Maxillofacial | <input type="checkbox"/> MRI Orbit, Face, Neck |
| <input type="checkbox"/> CT Coronal Sinus | <input type="checkbox"/> MRI Chest |
| <input type="checkbox"/> CT Soft-tissue Neck | <input type="checkbox"/> MRI Abdomen |
| <input type="checkbox"/> CT Chest | <input type="checkbox"/> MRI Pelvis |
| <input type="checkbox"/> CT Chest Limited for Interstitial Disease | <input type="checkbox"/> MRI C-Spine |
| <input type="checkbox"/> CT Abdomen | <input type="checkbox"/> MRI T-Spine |
| <input type="checkbox"/> CT Screen for Appendicitis | <input type="checkbox"/> MRI L-Spine |
| <input type="checkbox"/> CT Pelvis | <input type="checkbox"/> MRI Upper Extremity other than Joint |
| <input type="checkbox"/> CT Urogram | <input type="checkbox"/> MRI Upper Extremity Joint |
| <input type="checkbox"/> CT Limited Abdomen Follow-up | <input type="checkbox"/> MRI Lower Extremity other than Joint |
| <input type="checkbox"/> CT Upper Extremity | <input type="checkbox"/> MRI Lower Extremity Joint |
| <input type="checkbox"/> CT Lower Extremity | <input type="checkbox"/> MRI Breast Unilateral |
| <input type="checkbox"/> CT C-Spine | <input type="checkbox"/> MRI Breast Bilateral |
| <input type="checkbox"/> CT Myelogram C-Spine | <input type="checkbox"/> MRA Head |
| <input type="checkbox"/> CT T-Spine | <input type="checkbox"/> MRA Neck |
| <input type="checkbox"/> CT Myelogram T-Spine | <input type="checkbox"/> MRA Chest (non cardiac) |
| <input type="checkbox"/> CT L-Spine | <input type="checkbox"/> MRA Abdomen |
| <input type="checkbox"/> CT Myelogram L-Spine | <input type="checkbox"/> MRA Pelvis |
| <input type="checkbox"/> CT Angiogram | <input type="checkbox"/> MRA Upper Extremity |
| <input type="checkbox"/> CT Guidance for Steriotactic Localization | <input type="checkbox"/> MRA Lower Extremity |
| <input type="checkbox"/> CT Guidance for Needle Biopsy | <input type="checkbox"/> NC Myocardial Perfusion Study |
| <input type="checkbox"/> CT Guidance for Cyst Aspiration | <input type="checkbox"/> NC Wall Motion Study |
| <input type="checkbox"/> PET Scan - Brain | <input type="checkbox"/> NC Ejection Fraction |
| <input type="checkbox"/> PET Scan - Body/Cardiac | <input type="checkbox"/> NC MUGA |

*MedSolutions will provide our best efforts in satisfying your scheduling requests.
 However, we cannot guarantee that we will be able to secure the appointment time or facility of your choice.*