Registration and Inventory of Medical Equipment
Fixed Magnetic Resonance Imaging Scanners
January 2012

Instructions
This is the legally required "Registration and Inventory of Medical Equipment" (G.S. 131E-177) for fixed magnetic resonance imaging (MRI) scanners. Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 27, 2012**.

1. Complete and sign the form
2. Return the form by one of two methods:
   a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov
   b. Mail the form to Kelli Fisk, Medical Facilities Planning Branch, 2714 Mail Service Center, Raleigh, NC 27699-2714.

Note: Fixed equipment operated in a facility licensed under a hospital should be reported on that hospital's license renewal application, and not duplicated on this form.

If you have questions, call Kelli Fisk in the Medical Facilities Planning Branch at (919) 855-3865 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Section 1: Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

   _____
   (Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

   _____
   (Street and Number)

   _____ (_____) _____
   (City) (State) (Zip) (Phone Number)

3. Chief Executive Officer or approved designee who is certifying the information in this registration form:

   _____
   (Name) (Title)

   _____
   (Street and Number) (City) (State) (Zip)

   (_____) _____ _____
   (Phone Number) (Email)

4. Information Compiled or Prepared by: _____
   (Name)

   (_____) _____ _____
   (Phone Number) (Email)

Section 2: Equipment and Procedures Information

Time Period for Report: ☐ 10/01/2010 – 9/30/2011 ☐ Other time period: _____

(Please make additional copies of pages of this form as needed.)

	Scanner Number ____	**Scanner Number ____**
Manufacturer/Tesla		
Model Number		
Open or Closed Scanner		
Serial or I.D. Number		
Date of acquisition		
Purchase price (if purchased)		
Certificate of Need Project ID		
Certificate Holder, as listed on Certificate of Need		
If Leased or Rented, Name Owner of Equipment		
Service Site Information: Please include **all** of the information requested for each location.	Service Site_____ Address _____ _____ City, State, Zip _____ County _____	Service Site_____ Address _____ _____ City, State, Zip _____ County _____
Inpatient Procedures*: - with Contrast or Sedation - without Contrast or Sedation Outpatient Procedures*: - with Contrast or Sedation - without Contrast or Sedation **Total Number of Procedures**	Inpatient: with: _____ w/out: _____ Total: _____ Outpatient: with: _____ w/out: _____ Total: _____ **Total**: _____	Inpatient: with: _____ w/out: _____ Total: _____ Outpatient: with: _____ w/out: _____ Total: _____ **Total**: _____
Put a check by the days per week, and write in the number of hours per day, the scanner is in operation.	___ Sun: ____ hours ___ Mon: ____ hours ___ Tue: ____ hours ___ Wed: ____ hours ___ Thu: ____ hours ___ Fri: ____ hours ___ Sat: ____ hours	___ Sun: ____ hours ___ Mon: ____ hours ___ Tue: ____ hours ___ Wed: ____ hours ___ Thu: ____ hours ___ Fri: ____ hours ___ Sat: ____ hours
Total number of hours in operation for 10/1/2010 - 9/30/2011		

*An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. **The total number of procedures should be equal to or more than the total number of patients reported on the MRI Patient Origin Table on page 5 of this form.**

Name of entity that acquired the equipment (from page 1) _____

Section 3: MRI Procedures by CPT Code by Service Site

Please write the number of procedures provided by CPT Code during the time period of this report. Report separately for each service site. Make additional copies of pages 3 and 4 as needed. The total number of procedures should equal the total number of procedures reported on page 2 of this form.

Service Site Name: _____

CPT Code	CPT Description	Number of Procedures
70336	MRI Temporomandibular Joint(s)	
70540	MRI Orbit/Face/Neck w/o	
70542	MRI Orbit/Face/Neck with contrast	
70543	MRI Orbit/Face/Neck w/o & with	
70544	MRA Head w/o	
70545	MRA Head with contrast	
70546	MRA Head w/o & with	
70547	MRA Neck w/o	
70548	MRA Neck with contrast	
70549	MRA Neck w/o & with	
70551	MRI Brain w/o	
70552	MRI Brain with contrast	
70553	MRI Brain w/o & with	
7055A	IAC Screening	
71550	MRI Chest w/o	
71551	MRI Chest with contrast	
71552	MRI Chest w/o & with	
71555	MRA Chest with OR without contrast	
72126	Cervical Spine Infusion only	
72141	MRI Cervical Spine w/o	
72142	MRI Cervical Spine with contrast	
72156	MRI Cervical Spine w/o & with	
72146	MRI Thoracic Spine w/o	
72147	MRI Thoracic Spine with contrast	
72157	MRI Thoracic Spine w/o & with	
72148	MRI Lumbar Spine w/o	
72149	MRI Lumbar Spine with contrast	
72158	MRI Lumbar Spine w/o & with	
72159	MRA Spinal Canal w/o OR with contrast	
72195	MRI Pelvis w/o	
72196	MRI Pelvis with contrast	
72197	MRI Pelvis w/o & with	
72198	MRA Pelvis w/o OR with Contrast	
73218	MRI Upper Ext, other than joint w/o	
73219	MRI Upper Ext, other than joint with contrast	
73220	MRI Upper Ext, other than joint w/o & with	
	Subtotal for page	

Section 3: MRI Procedures by CPT Code by Service Site continued

Service Site Name: _____

CPT Code	CPT Description	Number of Procedures
73221	MRI Upper Ext, any joint w/o	
73222	MRI Upper Ext, any joint with contrast	
73223	MRI Upper Ext, any joint w/o & with	
73225	MRA Upper Ext, w/o OR with contrast	
73718	MRI Lower Ext other than joint w/o	
73719	MRI Lower Ext other than joint with contrast	
73720	MRI Lower Ext other than joint w/o & with	
73721	MRI Lower Ext any joint w/o	
73722	MRI Lower Ext any joint with contrast	
73723	MRI Lower Ext any joint w/o & with	
73725	MRA Lower Ext w/o OR with contrast	
74181	MRI Abdomen w/o	
74182	MRI Abdomen with contrast	
74183	MRI Abdomen w/o & with	
74185	MRA Abdomen w/o OR with contrast	
75552	MRI Cardiac Morphology w/o	
75553	MRI Cardiac Morphology with contrast	
75554	MRI Cardiac Function Complete	
75555	MRI Cardiac Function Limited	
75556	MRI Cardiac Velocity Flow Mapping	
76093	MRI Breast, unilateral w/o and/or with contrast	
76094	MRI Breast, bilateral w/o and/or with contrast	
76125	Cineradiography to complement exam	
76390	MRI Spectroscopy	
76393	MRI Guidance for needle placement	
76394	MRI Guidance for tissue ablation	
76400	MRI Bone Marrow blood supply	
7649A	MR functional imaging	
7649D	MRI infant spine comp w/ & w/o contrast	
7649E	Spine (infants) w/o infusion	
7649H	MR functional imaging	
N/A	Clinical Research Scans	
	Subtotal for page	
	Total Number of Procedures (both pages)	

Total Number of Procedures for All Service Sites: _____

Section 4: Patient Origin Data by Service Site

Please provide the county of residence for each patient who received MRI services during the time period of this report. Provide patient origin data separately for each service site. Make additional copies of this page as needed. The total number of patients receiving services should be equal to or less than the total number of procedures reported on page 2 of this form.

Service Site Name: _____

County in which service was provided: _____

Patient County	Number of Patients	Patient County	Number of Patients	Patient County	Number of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other (specify)	
35. Franklin		71. Pender			
36. Gaston		72. Perquimans		**Total Number of Patients**	

Name of entity that acquired the equipment (from page 1) _____

Section 5: Reimbursement/Payment Source

Please provide the source of reimbursement/payment for MRI procedures. Total procedures should equal the total number of procedures reported on page 2 of this form.

Primary Payer Source	Number of MRI Procedures
Self Pay	
Medicare & Medicare Managed Care	
Medicaid	
Commercial Insurance	
Managed Care	
Unreimbursed Care (Indigent/Charity)	
Other (Specify)	
Total	

Section 6: Certification and Signature

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

Signature _____

Print Name _____

Date signed _____

Please complete all sections of this form and return to the Medical Facilities Planning Branch by **Friday, January 27, 2012**.

1. Complete and sign the form
2. Return the form by one of two methods:
   a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov
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