MBS Imaging, LLC

COMPLETE CONVENIENT COST-EFFECTIVE

Simply send MBS Imaging a referral:

Sending Referrals

- Simply Fax or Email us a copy of:
  1. **Doctors Order** (from the chart)
  2. **Face sheet** (from the chart)
  3. **Patient Consent Form** (attached)
  4. **Dysphagia Consult Request Form** (attached)
- You will receive a call scheduling the test the day before with a designated 2-hour window.

Day of Evaluation

- The MBS team will call or text the person listed as the **contact** when 20 minutes away.
- Please have the patient ready in the front lobby.
- Therapists, Nursing, and Family are welcome to observe the evaluation.

Receiving Results

- MBS Imaging provides a **DVD copy** of the exam immediately after the evaluation and a written **diet recommendation slip**.
- Our **detailed written report** will be emailed or faxed the same day.

Welcome to **MBS Imaging**

Chicagoland's only **complete** mobile dysphagia diagnostic solution. MBS imaging specializes in the management of patients with **swallowing problems**. MBS serves over 250 SNFs, Assisted Living, CCRCs, and Home Health companies by providing on-site endoscopic and fluoroscopic instrumental swallow evaluations at the fingertips of healthcare providers with an unrivaled timely and cost-effective service.

- Multilingual staff
- Can fit any size wheel chair
- MBSS and FEES
- **Ideal** service for patients who are coughing while eating, developing wet voice, complaining of food sticking, desiring a diet upgrade, choking, or more.

Contact Info

P: 877-495-7152
F: 877-495-7208
fax@mbsimaging.com

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solutions

Facility Check List MBSS/VFSS

1. Please submit all required information listed below:

   ☐ MBSS/DYSPHAGIA CONSULT REQUEST FORM

   ☐ AUTHORIZATION FORM SIGNED BY PATIENT/RESPONSIBLE PARTY

   ☐ COPY OF PHYSICIAN'S WRITTEN ORDER

   ☐ COPY OF PATIENT'S FACE SHEET WITH INSURANCE INFORMATION

   ☐ IF POSSIBLE, A COPY OF PATIENT'S MEDICARE, MEDICAID, OR OTHER INSURANCE CARDS

2. Facility staff is responsible for having the patient(s) in a wheelchair with **VITAL SIGNS** ready for the study before the estimated arrival time.

WE APPRECIATE YOUR REFERRAL – THANK YOU!

1919 S. Highland Ave. Building (C) Suite 100 Lombard, IL 60148 *Phone*: (877) 495-7152 • *Fax*: (877) 495-7208

MBS IMAGING, LLC

Mobile Dysphagia Diagnostic Solution

MBSS/DYSPHAGIA CONSULT REQUEST FORM

Patient Name: _____ ☐ M or ☐ F

DOB: _____ AGE: _____ Ordering Physician's Name: _____

Facility: _____ Patient Hall / Room #: _____

Facility or Rehab Phone #: _____

Facility or Rehab Fax #: _____

SLP or Nurse Contact Number or Cell Phone: _____

REASON FOR MBSS/DYSPHAGIA CONSULT: (Check ALL that apply)

☐ s/s Aspiration	☐ change in P/O function	☐ diet upgrade	☐ least restrictive diet
☐ pleasure feed	☐ choking	☐ cough	☐ distress
☐ runny nose	☐ wet voice	☐ low weight	☐ other _____

PATIENT CONDITION & DIET: (Check ALL that apply)

COGNITION: ☐ Good ☐ Fair ☐ Poor ☐ Vent ☐ Trach ALLERGIES: _____

DIET STATUS: ☐ Peg ☐ NPO ☐ Regular ☐ Mech Soft ☐ Puree ☐ Pudding
☐ Honey ☐ Nectar ☐ Thin ☐ Teeth ☐ Dentures

AMBULATORY STATUS: ☐ Walks without assistance ☐ Wheelchair
☐ Geri-Chair ******Please call office for special instructions******

Other Pertinent information: _____

MBSS DIAGNOSES CODES

PRIMARY DIAGNOSIS:

☐ J69.8 Pneumonitis (due to solids/liquids)
☐ I69.991 Dysphagia Cerebrovascular disease (CVA)

ICD 10 Codes Below require a secondary diagnosis:

☐ R13.0 Dysphagia, unspecified difficulty in swallowing NOS
☐ R13.11 Dysphagia, oral phase
☐ R13.12 Dysphagia, oropharyngeal phase
☐ R13.13 Dysphagia, pharyngeal phase
☐ R13.14 Dysphagia, pharygoesophageal phase
☐ R13.19 Other dysphagia

SECONDARY DIAGNOSIS:

☐ Dyskinesia of esophagus
☐ Diverticulum of Esophagus, acquired
☐ Esophageal Reflux
☐ Eosinophilic Esophagitis
☐ Feeding difficulties & mismanagement
☐ Hereditary Progressive Muscular Dystrophy
☐ Malignacies of Head , Face, & Neck
☐ Malignacies of Esophagus
☐ Motor Neuron Disease
☐ Multiple Sclerosis
☐ Myasthenia Gravis
☐ Other specified infantile cerebral palsy
☐ Paralysis of vocal cords or larynx
☐ Parkinson's disease
☐ Stricture & Stenosis of Esophagus
☐ Systemic Sclerosis
☐ Other _____

BILLING PAY TYPE

☐ Part A Covered Stay (SNF)
☐ Medicare Part B (speech therapy bill)
☐ Medicaid Only
☐ HMO/ Managed Care
☐ Private Insurance
☐ VA Contract
☐ Cash Pay _____

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AUTHORIZATION FORM FOR MOBILE MODIFIED BARIUM SWALLOW STUDY

SECTION 1	Procedure Authorization

I hereby authorize MBSS Mobile to:

- Perform a Mobile Modified Barium Swallow (MBSS/VFSS) Study, in order to obtain an objective assessment of the swallowing function and to provide evaluation recommendations for diet, nutrition, compensatory strategies and other appropriate referrals.

SECTION 2	Billing Authorization

I hereby authorize:

- The release of any and all information required by MBSS Mobile for services furnished to me in order to process insurance claims on my behalf. In consideration of services rendered. I hereby assign and transfer to MBSS Mobile all rights, titles and interest benefits payable on all of my insurance carriers.
- The insurance carriers (Medicare Part B, Medicaid, or other Private Insurance) listed on the patient face sheet to pay directly to MBSS Mobile all benefits due under said policies by reason of services rendered herein. In the event the insurance carriers reimburse the patient in error, payment will be directly forwarded to MBSS Mobile for payment.

I will pay MBSS Mobile:

- The 20 percent co-pay and/or deductible remaining from Medicare Part B in the event I have no secondary coverage policy.
- The remaining balance if the patient's private insurance policy does not cover the 20 percent co-pay/or deductible, or if the patient's secondary policy does not cover an MBSS study.
- I will pay the account balance in full. (Either the full price of the test or the 20 percent co-pay /deductible) in the event Medicare Part B and/or Medicaid eligibility cannot be determined.

Patient's Printed Name: _____ Date: _____ / _____ / _____

Patient Signature: _____

Responsible Party or Power of Attorney Signature: _____

If received verbal consent only, please document in medical chart and sign here: _____

The facility must provide a copy of this signed Authorization by the patient (if able), the responsible party, or the person who has Power of Attorney prior to the MBSS being performed. The MBSS cannot be performed without this Authorization form.

******A photocopy of this authorization will be considered as effective and valid as the original******

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