**Registration and Inventory of Medical Equipment**

Mobile Magnetic Resonance Imaging Scanners

January 2025

**Instructions**

This is the legally required “Registration and Inventory of Medical Equipment” (G.S. 131E-177) for mobile magnetic resonance imaging (MRI) scanners. Please complete all sections of this form and return to Healthcare Planning by **Friday, January 24, 2025**.

1. **Submit one completed Registration and Inventory form per MRI scanner.**
2. Complete and sign the form
3. Return the form by one of two methods:
4. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.
5. Mail the form to Andrea Emanuel, Healthcare Planning, 2704 Mail Service Center, Raleigh, NC 27699-2704.

If you have questions, call Andrea Emanuel in Healthcare Planning at (919) 855-3954 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)

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street and Number)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. 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)

1. Information compiled or prepared by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name)

(\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Phone Number) (Email)

**Section 2: Equipment and Procedures Information**

Reporting Period: 🞎 10/01/2023 – 9/30/2024 🞎 Other time period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do not make extra copies of this page if the entity has multiple MRIs. Submit a complete, separate R&I form for each scanner.**

(Please make additional copies of this page as needed for additional Service Sites.)

|  |  |
| --- | --- |
| For DHSR Planning Use Only: |  |
| Manufacturer/Tesla |  **/** |
| Model number |  |
| Open or closed (including open bore) scanner | ⬜ Open ⬜ Closed |
| Serial or I.D. Number |  |
| Date of acquisition |  |
| Purchase price (if purchased) |   |
| Certificate of Need Project ID (or Legacy) |  ⬜ Legacy |
| Certificate holder, as listed on Certificate of Need  |  |
| If equipment went to only 1 site, is it permanently parked at that site? | ⬜ Parked ⬜ Not Parked |
|  | **Service Site Number \_\_\_\_\_** |
| Service Site Information: Please include **all** the information requested for each location.  | Service Site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Procedures**\***: - with Contrast or Sedation - without Contrast/ Sedation -Total inpatient/outpatient**Total Number of Procedures** | **Inpatient:** **Outpatient:** with: \_\_\_\_\_\_\_\_\_ with: \_\_\_\_\_\_\_\_\_ w/out: \_\_\_\_\_\_\_\_\_ w/out: \_\_\_\_\_\_\_\_\_ Total: \_\_\_\_\_\_\_\_\_ Total: \_\_\_\_\_\_\_\_\_**Total**: \_\_\_\_\_\_\_\_\_\_\_\_ |
| For each day of the week, enter the **number of hours** the scanner is in operation.  | \_\_\_ Sunday \_\_\_ Thursday\_\_\_ Monday \_\_\_ Friday \_\_\_ Tuesday \_\_\_ Saturday\_\_\_ Wednesday  |
| Total number of hours in operation for reporting period |  |

**\***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 greater than the total number of patients reported on the MRI Patient Origin Table on page 3 of this form.**

**Section 3: 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 two of this form.

Service Site Number: \_\_\_\_

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** |  |

**Section 4: 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note: Healthcare Planning and Certificate of Need may request CPT codes for MRI procedures if further clarification is needed**.

Please complete all sections of this form and return to Healthcare Planning by **Friday, January 24, 2025**.

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