UniCare

Capsular Endoscopy

Precertification-Clinical Worksheet

Phone: 800-442-9300 / Fax: 800-848-3623

Patient name: _____ DOB: _____ Member ID: _____

Place of service (facility): _____

Facility address: _____

Facility phone: _____ Facility fax: _____ Facility NPI #: _____

Performing physician: _____

Physician address: _____

Physician phone: _____ Physician fax: _____ Physician NPI #: _____

Date of service: _____

DX (ICD-10): _____ Primary diagnosis: _____

CPT code: _____ Primary procedure: _____

Notification #: _____

Diagnosis/potential diagnosis:

___ Gastrointestinal bleeding with question of small bowel origin

___ Suspected Crohn's disease

___ Suspected small intestinal tumors

___ Undiagnosed malabsorptive syndrome

___ Other (specify) _____

Diagnostic testing (specify with results):

___ Upper endoscopy/UGI (specify) _____

___ Colonoscopy with results _____

___ Small bowel follow-through (specify, if pertinent) _____

___ Other (specify) _____

Laboratory results (specify): _____

_____

Other: _____

_____

_____

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

After completing this form and obtaining the necessary clinical information, please fax to 800-848-3623.