UniCare

Procedure for Cardioverter-Defibrillator

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 #: _____

In order to review the medical necessity for this service, we need the following information:

- Documentation of medical necessity

Relevant diagnosis and past medical history (related to condition and including previous treatment, if applicable):

_____

_____

_____

_____

_____

If applicable:

___ Hx of cardiac arrest (date)_____ ___ VF/VT (specify) _____

___ Syncope ___ LVEF < 35% (specify) _____

___ Hx of MI (date) _____ ___ Nonischemic dilated cardiomyopathy

___ NYHA class (specify) _____ ___ Long QT syndrome

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

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