UniCare

Cervical Fusion

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 #: _____

Requesting physician: _____

Physician address: _____

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

Date of service: _____

CPT code: _____ Primary procedure: _____

If related to an accident, please indicate date, type, and location: _____

Notification #: _____

Diagnosis / possible indications (check all that apply):

___ Symptomatic cervical radiculopathy

___ Symptomatic cervical pseudarthrosis

___ Symptomatic single level or multilevel spondylotic myelopathy

___ Symptomatic nontraumatic cervical spondylosis with instability documented by radiographic findings

___ Degenerative cervical kyphosis with spondylosis causing cord compression

___ Infection of the cervical spine requiring decompression **or** debridement

___ Nontraumatic atlantoaxial (C1-C2) instability, cord compression, **or** subluxation (greater than 5 mm as documented by imaging studies)

___ Posttraumatic cervical instability

___ Ossification of the posterior longitudinal ligament (OPLL)

___ Spinal repair with fusion

___ Tumor of the cervical spine (primary bone or metastatic tumor) causing cord compression, instability, or pathologic fracture

___ Herniated nucleus pulposus

___ Osteophyte formation

___ Connective tissue disorders

___ Down syndrome

___ Os odontoideum

___ Skeletal dysplasia

___ Other (specify) _____

Symptoms / physical findings on exam (check all that apply):

___ Neurologic deficit
___ Progressive numbness or weakness
___ Unremitting radicular pain
___ Hardware failure
___ Sagittal plane angulation
___ Cervical stenosis
___ Bowel or bladder incontinence
___ Gait abnormality
___ Frequent falls
___ Hyperreflexia
___ Hoffman sign
___ Subluxation or translation
___ Myelopathy
___ Excision of the lesion
___ Other (specify)_____

Previous radiology exams of cervical spine (specify results):

___ Plain X-ray _____ MRI _____ CT scan
___ Myelogram _____ Other (specify) _____

Previous treatment (check all that apply and specify duration):

___ Non-weight bearing _____ Ice _____ Immobilization
___ Physical therapy _____ Oral corticosteroids _____ Nonsteroidal anti-inflammatory drugs
___ Chiropractor _____ Previous fusion (date and result)_____
___ Other (specify)_____

Duration/results: _____

_____

History: __Acute injury __History of trauma

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____

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