UniCare

Stimulator / CPM Machine / TENS Unit

Precertification-Clinical Worksheet
Phone: 800-442-9300 / Fax: 800-848-3623

Patient name: _____ DOB: _____ Member ID: _____

Provider: _____

Provider address: _____

Provider phone: _____ Provider fax: _____ Provider NPI #: _____

Requesting physician: _____

Physician address: _____

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

Equipment start date: _____ New: _____ Used: _____

Rental or purchase? _____

Notification #: _____

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

- Prescription for the requested durable medical equipment
- Documentation of medical necessity
- Replacement equipment requires documentation of disrepair / out of warranty

Relevant diagnosis and past medical history (include previous treatments and dates):

_____

_____

Date of surgery and type of surgery or injury: _____

_____

Is this injury work related? ___Yes ___No

Is this injury a result of a motor vehicle accident? ___Yes ___No

Functional status (specify): _____

_____

Where does the patient reside? ___Own home ___SNF ___Other (specify) _____

How long do you anticipate the patient will require this equipment?

# of days _____ # of weeks _____ # of months _____ Indefinite _____

Types of medical equipment with HCPC codes and prices (circle requested information):

Type (specify): _____ HCPC _____ Purchase $ _____ Rental $_____ per D/W/M

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UniCare has preferred providers for DME services. To get the maximum benefit, a preferred provider must be used. UniCare covers the allowed rental charge up to the allowed purchase price for approved durable medical equipment.

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

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