UniCare

Enteral Therapy

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

Patient name:_____ DOB:_____ Member ID:_____

Provider (agency/infusion company):_____

Provider address:_____

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

Requesting physician: _____

Physician address:_____

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

Referred to provider from: ___Hospital ___SNF ___Rehab ___Other: _____

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

Notification #: _____

Please note that the UniCare benefit is limited to medically necessary enteral nutrition provided through a tube into the stomach or intestines. UniCare does not cover oral enteral nutrition.

In order to review the medical necessity for this service, we need a prescription for requested formula/supplies, including diagnosis and frequency, duration, and route of therapy.

PMH: _____

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

Where will the patient have treatment? _____

Does the patient have a primary caregiver? ___No ___Yes (specify):_____

Social factors (family, community services): _____

Services requested (include B codes for medications):

Formula / supply name and code	Dosage	Route	Frequency	Start Date	Stop Date

Rates include skilled nursing? ___Yes ___No _____# of visits

UniCare has preferred providers for these services. To get the maximum benefit, a preferred provider must be used.

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____

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