UniCare

Home Health Care

Precertification-Clinical Worksheet

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

Patient name: _____ DOB: _____ Member ID: _____

Agency: _____

Agency address: _____

Agency phone: _____ Agency fax: _____ Agency NPI #: _____

Requesting physician: _____

Physician address: _____

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

Referred to agency from: ___Hospital ___ALF ___Rehab ___Other: _____

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

Notification #: _____

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

- Verification of type and frequency of service
- Documentation of medical necessity

PMH: _____

Current medical and functional status summary (pertaining to home services):

Homebound? ___No ___Yes (specify) _____

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

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

Social factors (family, community services): _____

Goals: _____

_____

Treatment plan (include wound measurements (L x W x D), if applicable): _____

_____

_____

Services requested:

	# of Visits	From	To	Published Rate	Negotiated Rate
SKNS					
HHA					
PT					
OT					
ST					
MSW					

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.