UniCare

Hyperbaric Oxygen Therapy

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 #: _____

Start date: _____ Anticipated discharge date: _____ Treatment HCPC code: _____

Notification #: _____

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

- Prescription for the requested treatment
- Documentation of medical necessity

Relevant diagnosis and past medical history (related to treatment): _____

_____

_____

Diagnosis / possible indications (check all that apply):

___Acute peripheral arterial insufficiency

___Acute thermal burns: deep second degree or third degree in nature

___Acute traumatic ischemic

___Carbon monoxide poisoning

___Central retinal artery occlusion (CRAO)

___Chronic non-healing wounds

___Chronic refractory osteomyelitis (refractory osteomyelitis)

___Compartment syndrome

___Compromised skin graft or flaps

___Crush injuries

___Cyanide poisoning

___Decompression sickness

___Delayed radiation injury, including osteoradionecrosis, soft tissue radiation necrosis, radiation cystitis

___Gas or air embolism

___Gas gangrene (i.e., clostridial myositis and myonecrosis)

___Intracranial abscess

___Necrotizing soft-tissue infections

___Prophylactic pre- and post-treatment for individuals undergoing dental surgery of a radiated jaw

___Severe anemia with exceptional blood loss: when transfusion is impossible or delayed

Systemic treatment:_____

Topical treatment: _____

Conservative therapy:

Type of therapy Date of therapy Results

_____

_____

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____

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