UniCare

Inpatient Medical

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 #: _____

Admitting physician: _____

Physician address: _____

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

Admission date: _____ Procedure date: _____

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

CPT code: _____ Primary procedure: _____

If this is a Medicare prime patient, please indicate the number of hospital days used in this benefit period: _____

Notification #: _____

Height: _____ Weight: _____

Past medical history / co-morbidities: _____

_____

Treatment plan: _____

_____

Surgical / diagnostic / invasive procedures: _____

_____

Complications or additional conditions diagnosed during this admission: _____

_____

Social factors (family, community services): _____

_____

Discharge:

Discharge planner's name: _____ Phone: _____

Discharge date: _____ Discharge plans: _____

Anticipated discharge needs: ___ Rehab ___ SNF ___ HHC* ___ HI* ___ DME* ___ Outpatient PT ___ Outpatient OT ___ Hospice

* *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.