UniCare

Inpatient Rehabilitation

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: _____ Estimated length of stay: _____ PMH: _____

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

CPT code: _____ Primary procedure: _____

Notification #: _____

Height: _____ Weight: _____

Level of function

Prior level of function: _____

Current level of function: _____

Level of function key: 1=Dependent 2=Max. assist 3=Mod. assist 4=Min. assist 5=Independent

	PLOF	CLOF		PLOF	CLOF		PLOF	CLOF	
ADLs:			Feed			Bathing			Groom
			Dress upper			Dress lower			Bladder
			Bowel						
Mobility/transfers:			Bed/chair			Toilet			Tub/shower
			Ambulate			Stairs			W/C
Communication:			Comprehension			Expression			Swallowing
Mentation:			Social interaction			Problem solving			

Social factors (family, community services): _____

Treatment plan (including frequency of PT, OT, and ST): _____

_____

_____

Goals: _____

_____

_____

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.