UniCare

Knee Arthroscopy

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 #: _____

Date of service: _____

CPT code: _____ Primary procedure: _____

If related to an accident, please indicate date, type, and location: _____

Notification #: _____

Diagnosis/possible indications (check all that apply):

___ Intra-articular joint pathology
___ Torn meniscus
___ Baker's cyst
___ Articular cartilage lesions
___ Patellar compression syndrome
___ Fracture reduction of some bones in the knee
___ Chronic inflammatory disease
___ Rheumatoid arthritis
___ Arthrofibrosis
___ Anterior cruciate ligament (ACL) or posterior cruciate ligament (PCL)

Symptoms and physical findings on exam (check all that apply):

___ Knee pain and tenderness
___ Knee locking
___ +McMurray's sign
___ Displaced lesion
___ Nondisplaced lesion
___ Joint instability
___ Knee swelling and/or tenderness
___ Unstable tear or tear greater than 10mm when < 18 years of age
___ Loose or foreign body with confirmatory evidence
___ Other (specify) _____

Previous radiology exams of knee (specify results):

___ Plain X-ray ___ Bone scan ___ Ultrasound
___ MRI ___ Other (specify) _____

Results: _____

Previous treatment (check all that apply and specify duration):

___ Non-weight bearing ___ Ice ___ Immobilization ___Physical therapy ___ Chiropractor

___ Other (specify)_____

Duration/results: _____

_____

History: __Acute injury __History of trauma

Signature:_____ **Date**:_____

Print name:_____ **Phone**: _____

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