UniCare

MRI / CT / PET / SPECT Scan

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: _____

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

CPT code: _____ Primary procedure: _____

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

Notification #: _____

Diagnosis / possible indications (check all that apply):

___ Spine fracture (level)_____
___ Primary or metastatic bone cancer
___ Breast cancer
___ Spinal osteomyelitis
___ Cauda equina syndrome
___ GYN cancer (specify)_____
___ Suspected loosening of prosthesis or cement
___ Anatomical abnormality of the heart (specify)_____
___ Nephrolithiasis
___ Ascites
___ Liver mass
___ Adrenal mass
___ Pancreatic mass
___ Pancreatitis
___ Pancreatic pseudocyst
___ Appendicitis
___ Abdominal abscess
___ Diverticulitis
___ Thymoma
___ Other (specify)

___ Spinal tumor (level) _____
___ Suspected primary or metastatic bone cancer
___ Potential breast cancer BRAC/other _____
___ Demyelinating disease (specify) _____
___ Meningocele/Myelomeningocele
___ Tumor (site) _____
___ Epidural abscess
___ Lung mass/nodule (specify 1st date diagnosed)_____
___ Lung cancer
___ Emphysema/COPD
___ Atelectasis
___ Pleural effusion
___ Bronchiectasis
___ Pulmonary embolus
___ Mediastinal mass
___ Hilar enlargement
___ Thoracic aneurysm
___ Myasthenia gravis
___ Coronary artery disease (specify)

_____ _____

Symptoms/objective:

___ Cough ___ Mental status changes ___ Dysphagia

___ Nausea/vomiting ___ Dyspnea ___ Hemoptysis

___ Fecal incontinence ___ Rebound tenderness ___ Hemiparesis

___ Hematuria ___ Abdominal pain / flank pain (circle)

___ Temperature > 100.4 (duration)_____

___ Neurological deficits (specify) _____

___ Weight loss exceeding 10% body weight over a short time

___ Palpable abdominal or pelvic mass

___ Abnormalities noted on other imaging or laboratory studies (specify) _____

___ Other (specify)_____

Previous radiology exams with findings:

___ Plain films ___ CT scan ___ Ultrasound

___ MRI ___ Barium enema ___ MRA ___ Radiation

___ Nuclear medicine (specify) _____

___ Other (specify)_____

Findings: _____

_____

Applicable lab tests with results: _____

_____

Applicable medications:

Dosage Frequency Date Started Date Ended

_____

_____

Previous treatment:

___ OT (duration and effectiveness) _____

___ PT (duration and effectiveness) _____

___ Chiropractic (duration and effectiveness) _____

___ Surgery (type, date, etc.) _____

___ Other (type and duration) _____

_____

Additional comments: _____

_____

_____

Signature:_____ **Date**:_____

Print name:_____ **Phone**: _____

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