UniCare

Meniscal Allograft Transplant

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 #: _____

Performing physician: _____

Physician address: _____

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

Date of service: _____

CPT code: _____ Primary procedure: _____

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

Notification #: _____

Diagnosis/possible indications (check all that apply):

___ Significant partial (more than 50%) percent of loss of meniscus _____

___ Complete loss of the meniscus

Symptoms (check all that apply):

___ Skeletally mature up to and including age 55 years

___ Disabling knee pain refractory to conservative treatment

___ Ligamentous stability prior to surgery or achieved concurrently with meniscal transplantation

___ Documented mild to moderate articular damage (Outerbridge grade II or less)

___ Normal alignment without varus or valgus deformities

Previous radiology exams of knee (specify results and date of exam):

___Plain X-ray (date)_____ ___Bone scan (date)_____ ___Ultrasound (date) _____

___MRI (date)_____ ___Other (specify) _____ (date) _____

Results: _____

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

___ Physical therapy ___Other (specify) _____

Duration/results: _____

History: ___ Acute injury ___ History of knee fracture ___ History of knee surgery (date) _____

___ History of trauma ___ History of diagnostic knee arthroscopy (date)_____

Results: _____

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

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