UniCare

Outpatient Surgery

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: _____

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

CPT code: _____ Primary procedure: _____

Notification #: _____

Indications for surgery: _____

_____

_____

Symptoms/functional limitations: _____

_____

_____

Diagnostic testing with results: _____

_____

_____

Conservative therapy: _____

_____

_____

Applicable lab tests with results: _____

_____

Applicable medications with dose, frequency: _____

_____

Additional comments: _____

_____

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

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