UniCare

Sinus 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 #: _____

In order to review the medical necessity for this service, we need the following information:

- Documentation of medical necessity

Diagnosis/possible indications (check all that apply):

___ Rhino sinusitis ___acute ___chronic
___ Polyps (specify location)_____
___ Deviated septum
___ Migraine headaches
___ OSA (obstructive sleep apnea)
___ Encephalocele
___ Polyposis
___ Other _____

___ Tumor (specify) _____
___ Abscess (specify)_____
___ Chronic polyposis
___ Mucocele
___ Fungal mycetoma
___ Epistaxis
___ Abscess (specify)_____

Symptoms (e.g., post-nasal drip): _____

_____

Diagnostic testing (specify with results; e.g., CT scans and biopsies)**:** _____

_____

Conservative therapy including medications oral/topical (specify with results): _____

_____

Previous surgeries (specify with dates and findings): _____

_____

_____

Signature: _____ **Date**: _____

Print name: _____ **Phone**: _____

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