UniCare

Spinal / Neurological Procedure

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: _____ Day surgery? _____ If inpatient, requested length of stay: _____

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

Indications for surgery: _____

Symptoms / functional limitations: _____

Diagnostic testing: _____

Results: _____

Previous surgeries, including dates of surgeries: _____

_____

Applicable lab tests (specify with results):

_____

_____

_____

Applicable medications:

Dosage	Frequency	Date Started	Date Ended

_____

_____

_____

Conservative therapy (specify with results)

_____

_____

_____

Psychological evaluation completed? ___No ___Yes (results): _____

Will surgery include an artificial disc? ___No ___Yes

For this procedure, will rhBMP-2 or rhBMP-7 be used? ___rhBMP-2 ___rhBMP-7 ___None

If yes (rhBMP-2 or rhBMP-7 is being used):

___ Recombinant human bone morphogenetic protein-2 (rhBMP-2) InFUSE bone graft is being used.
Reason for use:

___ As an adjunct to instrumented anterior lumbar interbody fusion (ALIF) procedure

___ As an adjunct to instrumented posterolateral lumbar inter-transverse (PLIF) fusion procedure

_____

___ Other reason (specify) _____

_____

Is recombinant human bone morphogenetic protein-7 (rhBMP-7) Osteogenic Protein-1TM (OP-1 TM Implant) being used in the following situations:

___ In a revision of a plif posterolateral lumbar inter-transverse fusion, was person compromised. If so, why?

_____

___ Can an autologous bone marrow harvest be done? If not, for what other reason?

_____

Signature:_____ **Date**: _____

Print name:_____ **Phone**: _____

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