PRIOR AUTHORIZATION for VARICOSE VEIN TREATMENT

For authorization, please complete this form, and FAX to the *PEHP Clinical Management Department* at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Member & Provider Services at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Section II: PROVIDER(S) INFORMATION

***Rendering* Provider:**			***Rendering* Provider Address:**		
Provider NPI #:	**Provider TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

***Facility/Hospital*:**			***Facility/Hospital* Address:**		
Facility NPI #:	**Facility TIN #:**	**Contact Person:**	**Phone:** ( )	**Facsimile:** ( )	**Email Address:**

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*

☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

Requested Date(s) of Service:

From: **To:**

Place of Service: ***Please check.***

☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient

Primary Diagnosis/ICD-10 Code:

Secondary Diagnosis/ICD-10 Code:

A. Lower Extremity Symptoms: ***Please check all that apply.***

☐ Aching ☐ Bleeding Varicosity ☐ Chronic Cellulitis ☐ Chronic Venous Hypertension
☐ Cramping ☐ Edema/Swelling ☐ Fatigue ☐ Fullness
☐ Heaviness ☐ Itching ☐ Non-Healing Ulcer(s) ☐ Pain
☐ Recurrent Phlebitis/Thrombophlebitis ☐ Refractory Dependent Edema ☐ Restlessness ☐ Skin Changes
☐ Stasis Dermatitis ☐ Ulcers ☐ Other _____

B. Attempted Conservative Management: ***Please check all that apply.***

1. ☐ Activity Modification 2. ☐ Exercise 3. ☐ Leg Elevation 4. ☐ NSAIDs 5. ☐ Pressure Gradient Compression Stockings (at least 20-30 mm Hg) for at least 3-months

C. Lower Extremity Venous Duplex Ultrasound Results (mm/millimeter; ms/millisecond):

Date: _____ Vein: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

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Date: _____ Vein: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

D. Varicose Vein Treatment Being Requested: ***Please check all that apply.***

1. ☐ Endovascular Embolization with Cyanoacrylate Adhesive (VenaSeal Closure System) *CPT codes 36482-36483*
2. ☐ Endovenous Laser Ablation (EVLA) *CPT codes 36478-36479*
3. ☐ Ligation/Excision/Stripping *CPT codes 37700-37761, 37780, 37785*
4. ☐ Phlebectomy (*ambulatory, microphlebectomy, stab*) *CPT codes 37765-37766*
5. ☐ Radiofrequency Ablation (RFA) *CPT codes 36475-36476*
6. ☐ Sclerotherapy *(endovenous microfoam; Varithena® polidocanol injectable foam) CPT codes 36465-36466*
7. ☐ Sclerotherapy *(liquid, foam, ultrasound guided) CPT codes 36470-36471*
8. ☐ Subfascial Endoscopic Perforator Surgery (SEPS) *CPT code 37500*
9. ☐ Other: _____

E. Procedure Code(s) Requested: ***Please list all requested services regardless of pre-authorization requirement. Unlisted codes cannot be pre-authorized.***

Procedure: _____ CPT Code: _____ Vein: _____ ☐ Bilateral ☐ Left ☐ Right

Procedure: _____ CPT Code: _____ Vein: _____ ☐ Bilateral ☐ Left ☐ Right

Procedure: _____ CPT Code: _____ Vein: _____ ☐ Bilateral ☐ Left ☐ Right

Procedure: _____ CPT Code: _____ Vein: _____ ☐ Bilateral ☐ Left ☐ Right

Please be aware that some employer groups cover sclerotherapy (CPT codes 36470-36471) of varicose veins, except spider and reticular veins, and microphlebectomy (CPT codes 37765-37766), at 50% of maximum allowable fee per Master Policy. For all other employer groups these procedures are only covered if performed within 12-months of the primary procedure of the larger vein(s) on the same leg (e.g., EVLA, RFA, SEPS, Varithena, VenaSeal).

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

***Please fax completed form and medical records to 801-366-7449.**