PRIOR AUTHORIZATION for VARICOSE VEIN TREATMENT

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization 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 Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

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

Section II: PROVIDER INFORMATION

Date Requested:		Service Provider Name:
Service Provider NPI #:	Service Provider Tax ID #:	Service Provider Address:

Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.* ☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	**Requested Date of Service:**	**Place of Service:** *Please check.* ☐ Ambulatory Surgical Center ☐ Inpatient ☐ Office ☐ Outpatient
Primary Diagnosis/ICD-10 Code:		**Secondary Diagnosis/ICD-10 Code:**

A. Procedure(s) Requested: **Please be aware that sclerotherapy of varicose veins except for spider and reticular veins, microphlebectomy (stab phlebectomy), and trans illuminated powered phlebectomy (TIPP) are payable at 50% of maximum allowable fee per Master Policy.*

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

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

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

B. Does the patient endorse any of the following lower extremity symptoms? ☐ Yes ☐ No *Please check all that apply.*

☐ Aching ☐ Cramping ☐ Edema/Swelling ☐ Fatigue ☐ Fullness ☐ Heaviness ☐ Itching ☐ Pain ☐ Restlessness ☐ Skin Changes ☐ Ulcers

C. Did the patient receive a prescription for pressure gradient compression stockings of at least 20-30 mm Hg? ☐ Yes ☐ No

If "*yes*", how long has the patient been wearing them? _____

D. Has the patient also attempted other forms of conservative management? ☐ Yes ☐ No *Please check all that apply.*

☐ Activity Modification ☐ Exercise ☐ Leg Elevation ☐ NSAIDs ☐ Other *(please specify)*: _____

E. Has the patient previously received treatment and/or surgery for varicose veins? ☐ Yes ☐ No

Date: _____ Treatment: _____ Blood Vessel: _____ ☐ Left ☐ Right ☐ Bilateral

Date: _____ Treatment: _____ Blood Vessel: _____ ☐ Left ☐ Right ☐ Bilateral

Date: _____ Treatment: _____ Blood Vessel: _____ ☐ Left ☐ Right ☐ Bilateral

Date: _____ Treatment: _____ Blood Vessel: _____ ☐ Left ☐ Right ☐ Bilateral

F. Lower Extremity Venous Duplex Ultrasound Results: **Date of Study:** _____

Blood vessel: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

Blood vessel: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

Blood vessel: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

Blood vessel: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

Blood vessel: _____ ☐ Left ☐ Right Diameter (mm): _____ Reflux (ms): _____

Additional Comments:

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