Varicose Vein and Venous Insufficiency Treatment Procedures
Prior Authorization Request Form

Medica Central Health Plan requires that providers obtain prior authorization before rendering the above services. If any items on the Medica Central Health Plan Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims may be denied as provider liability.

Submission of this completed form certifies that the information is true and accurate. All fields are required for processing your request.

Patient Information	
Today's Date	Patient DOB Month / Day / Year
Patient Name	Patient Phone Number (Area Code + Number)
Patient's ID Number Group	Policy

Prior Authorization Information	
Facility Name	Facility Address
Facility Telephone Number	City State Zip
Facility Fax Number	Facility Tax ID Number (TIN)
Proposed Date of Service	
Service/Procedure Requested	Check One: ☐ Inpatient ☐ Outpatient
Diagnosis/ICD-10 Code(s) **must be a billable code	
CPT Code(s)	
Relevant Inpatient Surgical ICD-10 Code(s)	

Ordering Provider Information	
Provider Name	Clinic Name
Federal Tax ID	Address
NPI Number	City State Zip
Clinic Contact Name	Telephone Number Fax Number

Varicose Vein & Venous Insufficiency Treatment Procedures Request Form

Summary of Member's Clinical Information

KEY:
= Complete all boxes that apply

Endovenous Radiofrequency/Laser Ablation, Cyanoacrylate adhesive closure (Venaseal) or ligation/stripping/phlebectomy:

Name/Location of Vein(s) to be treated:

_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral

Sclerotherapy-

Name/Location of Vein(s) to be treated:

_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral
_____ ☐ Left ☐ Right ☐ Bilateral

Total Visits Requested for all procedures: _____

Is the following information included in your request?

☐ Detailed clinical history including documented pain level (moderate to severe) and interference on activities of daily living.

☐ Duplex ultrasound report of legs to be treated

☐ For patients with thrombophlebitis, dermatitis, ulceration or hemorrhage, adequate photographs, taken in the provider's office, under the provider's direction, documenting skin changes that account for functional impairment.

- *For Medicare sclerotherapy requests, photographs are required.*

Previous Vein Procedures:

Prior Vein(s) Treated:

Procedure:

Date of Procedure:

Submit form by utilizing the options below:

- For Commercial (Fully Insured/Self-Funded) and IFB Members: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com

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