



**BlueCross  
BlueShield**

Federal Employee Program.

Prior Authorization Request Form		<b>7.01.124 Treatment of Varicose Veins Venous Insufficiency</b>	
Standard Fax Number: 1 (855) 895-3504		<b>Urgent Fax Number: 1 (844) 244-0226</b>	
Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for medical requests and requests for medications covered under the medical benefit. Visit Provider Connection ( <a href="http://www.blueshieldca.com/provider">www.blueshieldca.com/provider</a> ) and click the Authorizations tab to get started.			
Notice: The Federal Employee Program has a <b>15 Calendar Day</b> turn-around time on all Standard Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.			
<input type="checkbox"/> New Standard Request		<input type="checkbox"/> New Urgent Request	
<b>Important For Urgent Requests:</b> Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. <i>If there is no MD signature present the request will be processed as a Standard request.</i>			
<b>MD Signature REQUIRED For Urgent Requests Only:</b>			
<input type="checkbox"/> Modification Or <input type="checkbox"/> Extension Requests Complete the Section Below:			
Date Last Authorized:		Previous Authorization Number:	
MD/NP/PA justification for modification or extension:			
<b>Patient Information:</b>			
First Name:		Last Name:	
Date of Birth:		ID Number:	
Address:			
<b>Referring/Prescribing Provider:</b>			
Name:		NPI:	
Street Address + Suite #:		Email address:	
City:	State:	Zip:	Phone:
Type of Provider: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist Type:		Fax:	
		Contact Name and Phone Number:	
<b>Servicing/Billing: Provider/Vendor/Lab</b> <i>If same as Referring/Prescribing Provider Check Here <input type="checkbox"/></i>			
Name:		NPI:	
Street Address + Suite #:		Email address:	
City:	State:	Zip:	Phone:
		Fax:	

Specialist Type:	Contact Name and Phone Number:
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**If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:**

Group Name:	NPI:	
Street Address + Suite #:		
City:	State:	Zip:

**Billing Facility (If Applicable):**

Facility Name:	NPI:			
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

**Anticipated Date of Service:** \_\_\_\_\_ **If Lab, Draw Date:** \_\_\_\_\_

**Place of Service: (Check One Box Only or If typing replace box with an "X"):**

<input type="checkbox"/> Office	<input type="checkbox"/> Home	<input type="checkbox"/> On Campus OP Hosp
<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> Hospice	<input type="checkbox"/> PHP
<input type="checkbox"/> Ambulance- Air or Water	<input type="checkbox"/> Independent Clinic	<input type="checkbox"/> RTC – Psychiatric
<input type="checkbox"/> Ambulance-Land	<input type="checkbox"/> Independent Laboratory	<input type="checkbox"/> RTC – SUD
<input type="checkbox"/> Ambulatory Surgical Center	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Intermediate Care Facility	<input type="checkbox"/> Telehealth
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> IOP	<input type="checkbox"/> Urgent Care Facility
<input type="checkbox"/> Custodial Care Facility	<input type="checkbox"/> IP Psychiatric Facility	<input type="checkbox"/> Other - Please Specify:
<input type="checkbox"/> End Stage Renal Disease TX	<input type="checkbox"/> Nursing Facility	
<input type="checkbox"/> Group Home	<input type="checkbox"/> Off Campus OP Hosp	

**Please enter all codes requested; unlisted codes must have a description.  
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.**

ICD-10 Code(s):

CPT/HCPC Code(s):

**For questions: Call FEP Authorization Requests Phone Number: 1 (800) 633-4581**

This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate, or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and **confidentially** destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.

Please provide the following documentation

History and physical and/or consultation notes including:

**Clinical findings**

- Primary diagnosis and relevant comorbidities
- Pertinent symptoms and duration to include, if applicable:
  - Ulceration due to venous incompetence
  - Recurrent thrombophlebitis
  - Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity
  - Other symptoms associated with venous reflux (i.e., pain, itching, burning, etc.)
- Activity and functional limitations
- Recent (i.e., **within 3 months of request**) doppler or duplex ultrasound with report indicating significant reflux in vein(s) planned for treatment - except for varicose tributaries.
- Documentation of diameter (in millimeters) of vessel(s) to be treated

**Prior treatment**

- All prior conservative treatments including:
  - Documentation of a trial of compression stockings for **at least 3 months** with response
  - Documentation of all other conservative therapies attempted (i.e., exercise, NSAIDS, etc.) with duration and response
- All prior vein treatments including:
  - Documentation of which veins received treatment including date(s) of service
  - Type of treatment administered
  - Result of treatment

**Rationale**

- Reason for requested treatment.
- Documentation of which leg(s) and which vein(s) are to be treated.
- Documentation of the planned method of treatment (i.e., laser ablation, stab phlebectomy--with number of stabs planned, etc.)
  - Note: Please indicate planned CPT codes with appropriate leg(s) and vessel:  
**[Example: CPT 36475 - Bilateral GSV]**
- Anticipated date(s) of service
- Treatment plan

View our Medical Policy online at <https://www.fepblue.org/legal/policies-guidelines>