Varicose Vein and Venous Insufficiency Treatment Procedures
Prior Authorization Request Form

Medica requires that providers obtain prior authorization before rendering the above services. If any items on the Medica Prior Authorization list are submitted for payment without obtaining a prior authorization, the related claim or claims will be denied as provider liability. The provider will have 60 days from the date of the claim denial to appeal and supply supporting documentation required to determine medical necessity.

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

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:

Please note that written documentation from the medical record supporting the procedure must be submitted for all requests. Failure to do so may result in a delay of the decision.

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

- For group numbers that begin with IFB or C: Fax to 952-992-2836 or E-Mail to ifbhealthmanagement@medica.com
- For group numbers that begin with A **(excluding A0061 & A00500):** Fax to 952-992-2396 or E-Mail to hpshealthmanagement@medica.com
- For all other group numbers **(including A0061 & A00500):** Fax to 952-992-3556 or E-Mail to caremanagement@medica.com
- U.S. Mail to Medica, Utilization Management and Clinical Appeals, PO Box 9310, CP440, Minneapolis, MN 55440