

Varicose Vein Authorization Form

Email completed form and supporting documents to: UtilizationManagement.OSUHealthPlan@osumc.edu
or Fax to (614) 292-2667

Patient Information

Patient Name:	
DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Member ID #:	
Phone #:	

Provider Information

Physician Name: Office
Contact Name: Office
Contact Phone #:
Secure Fax #:

Diagnosis / ICD-10-CM	Procedure Name / CPT code	Vein Being Treated	Extremity (RLE/LLE/ Bilateral)	Reflux Duration (ms)	Vein Diameter (mm)
				Right: Left:	Right: Left:
				Right: Left:	Right: Left:
				Right: Left:	Right: Left:
				Right: Left:	Right: Left:
				Right: Left:	Right: Left:
				Right: Left:	Right: Left:

Do the member's saphenous varicosities result in any of the following? *(Please include supporting documentation)*

- Ulceration
- Hemorrhage
- Recurrent Superficial Thrombophlebitis
- Severe and Persistent Pain and Swelling interfering with activities of daily living (ADLs)

Which of the following conservative treatments has the member attempted?

- Analgesics (Name: _____; Duration: _____)
- Prescription gradient support compression stockings (Duration: _____)

Were they effective at relieving the member's symptoms? YES NO

Has the member had previous invasive treatment(s) of lower extremity varicosities? YES NO

If yes, please describe (include dates): _____

Please include the following documentation:

- Doppler or duplex ultrasound study *(performed within the last 12 months)*
- Physician evaluation and treatment plan
- Documentation of conservative management

Requesting Physician Signature: _____ Date: _____

For questions, please contact the OSU Health Plan @ (614) 292-4700

<u>OSUHP USE ONLY</u>	
Authorization #:	Dates of Service:
OSU Health Plan contact:	Contact Phone #:
Comments:	

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