THE OHIO STATE UNIVERSITY HEALTH PLAN

# 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: ☐M ☐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:<br>Left: | Right:<br>Left: |
| | | | | Right:<br>Left: | Right:<br>Left: |
| | | | | Right:<br>Left: | Right:<br>Left: |
| | | | | Right:<br>Left: | Right:<br>Left: |
| | | | | Right:<br>Left: | Right:<br>Left: |
| | | | | Right:<br>Left: | Right:<br>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*

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