Varicose Vein Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Servicing Provider: ________________ **Fax**: ________________ **Phone**: ______________**Place of Service**:_____________
Diagnosis code:_______ **Procedure codes**:_________ __________ __________ **# of Units**:_____ **R Leg**____ **L Leg**____
Vein to be treated____________

For treatment of GSV, LSV, ASV, and symptomatic varicose tributaries

1. Is request for treatment of GSV, LSV, or ASV? _____ Yes _____ No ____ NA
2. Is there documented reflux in the vein to be treated? ______ Yes _____ No _____NA
3. If request is for treatment of the ASV has reflux in the GSV or LSV been previously eliminated? ____Yes ___No __NA
4. Is there documentation showing ulceration due to venous stasis or recurrent thrombophlebitis that failed to respond to compressive treatment; **OR** does the member have hemorrhage or recurrent bleeding from a ruptured varicosity?
   __ Yes __ No __NA
5. Does the member have symptomatic saphenous reflux, AND symptoms that interfere with ADL's, AND failure of conservative therapy (including compression therapy) for at least three months? __ Yes __ No __NA
6. If stab avulsion, hook phlebectomy, or transilluminated powered phlebectomy is being requested , is the request for one session per leg for symptomatic varicose vein treatment at the same time or within six months following treatment of the Saphenous vein ? ____ Yes ____ __ No _____NA
7. If request is for sclerotherapy, are < or equal to 3 sessions per leg being requested for symptomatic varicose vein treatment at the same time or within six months following treatment of the Saphenous vein ? __ Yes __ No __NA
8. Is request for either Stab Avulsion, hook phlebectomy, transilluminated. powered phlebectomy, or sclerotherapy of the GSV, LSV, ASV or perforator vein? _____Yes ____No _____NA

For treatment of Perforator Veins

1. Is request for treatment in a member with leg ulcer associated with chronic venous insufficiency who has documented perforator reflux? _____ Yes _____ No ______NA
2. Has reflux been previously eliminated in the GSV, LSV, or ASV? _____ Yes ______No ______NA
3. Does documentation show that member has failed compression treatment for at least three months? __ Yes ___No ___NA
4. Does documentation show that member's reflux is due to a DVT? ____ Yes _____ No _____NA
5. Is ligation or ablation of incompetent perforator vein being performed concurrently with superficial venous surgery?
   _____Yes _____No ______NA

Effective:11/29/10

PHYSICIAN ATTESTATION: By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available

Please certify the following by signing and dating below:

*Physician signature: ______________________________ Date: _________________
(*Original Physician signature required. Stamped signatures not acceptable)

For BCBSNC members, fax form to 1-800-571-7942
For NC State Health Plan members, fax form to 1-866-225-5258

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