

**Review Request  
for Treatment of Varicose Vein (lower extremities)**

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 05/21/09	Policy Effective Date: 07/15/09	Provider Tool Effective Date: 8/10/09
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Member Name:	Date of Birth:
Insurance Identification Number:	Member Phone Number:

Ordering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Rendering Provider Name and Specialty:	Provider ID Number:
Office Address:	
Office Phone Number:	Office Fax Number:

Facility Name:	Facility ID Number:
Facility Address:	

Date/Date Range of Service:	Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____
Service Requested (CPT if known):	
Diagnosis (ICD-9) if known:	

**Please check all that apply to the member:**

- Member has persistent symptoms interfering with activities of daily living despite non-surgical management. Symptoms include:
  - Aching, burning, itching, cramping, or swelling during activity or after prolonged sitting, or recurrent thrombophlebitis
  - Documentation reflects that properly fitted gradient compression stockings have been used for six weeks without resolving the symptoms
- Member has ulceration secondary to stasis dermatitis
- Member has hemorrhage from a superficial varicosity

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**Request is for:**

- Endoluminal radiofrequency ablation (also known as VNUS® Closure® System) or
- Endoluminal laser ablation (also known as EVLT™ or ELAS)

**Please check all that apply to the member:**

- Treatment of the greater or lesser saphenous veins when there is documentation of valvular incompetence (i.e., reflux) of the greater or lesser saphenous veins by Doppler or duplex ultrasound scanning
- Treatment as an alternative to perforator vein ligation
- Treatment of saphenous vein tributaries or extensions (e.g. anterolateral thigh, anterior accessory saphenous and Giacomini veins);
- Treatment as an alternative to adjunctive sclerotherapy or echosclerotherapy of symptomatic varicose tributaries
- Other treatment (please list): \_\_\_\_\_

**Request is for:**

- Sclerotherapy
- Echosclerotherapy (also known as Ultrasound-Guided Sclerotherapy)

**Please check all that apply to the member:**

- Procedure is part of a treatment plan including surgical ligation and stripping, endoluminal radiofrequency ablation, or endoluminal laser ablation of the greater or lesser saphenous veins
- Procedure is for sole treatment of symptomatic varicose tributary or perforator veins
- Procedure is performed as part of other protocols for sclerotherapy, including, but not limited to the COMPASS (Comprehensive Objective Mapping, Precise Image-guided Injection, Antireflux Positioning and Sequential Sclerotherapy) protocol, for the treatment of valvular incompetence (i.e., reflux) of the greater or lesser saphenous veins
- Treatment for symptomatic varicose tributary (e.g. anterolateral thigh, anterior accessory saphenous and Giacomini vein) or perforator veins when performed at the same time as surgical ligation and stripping, endoluminal radiofrequency ablation, or endoluminal laser ablation of the greater or lesser saphenous veins
- Treatment of residual or recurrent symptomatic disease following prior surgical ligation and stripping, endoluminal radiofrequency ablation, or endoluminal laser ablation of the greater or lesser saphenous veins
- Treatment of secondary varicose veins resulting from deep-vein thrombosis or arteriovenous fistulae when used to treat valvular incompetence (i.e. reflux) of the greater or lesser saphenous veins with or without associated ligation of the saphenofemoral junction
- Treatment of the telangiectatic dermal veins, which may be described as "spider veins" or "broken blood vessels"
- Other treatment (please list): \_\_\_\_\_

**Request is for:**

- Treatment using various laser treatments (including tunable dye or pulsed dye laser, e.g., PhotoDerm™, VeinLase™, Vasculite™) of the telangiectatic dermal veins, which may be described as "spider veins" or "broken blood vessels"
- Other: \_\_\_\_\_

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This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: \_\_\_\_\_
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

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Name and Title of Provider or Provider Representative  
Completing Form (Please Print)\*

Date

**\*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**