PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION!

JURISDICTION 15 PART A

PRIOR AUTHORIZATION OPD: VEIN ABLATION

PAR 255

All fields are REQUIRED unless otherwise noted.
Incomplete or illegible handwritten requests will be returned.

Note: Use of this request document will require submission via fax, mail, or the electronic submission of Medical Documentation (esMD). To save time, use the myCGS web portal to submit your request, upload your documentation electronically, track the status of your request, and receive a quicker response.

Request Type

Expedited Reason

Note: *Provide reason for expediting request if Expedited Initial or Expedited Resubmission Request Type is selected above.*

Requested HCPCS (maximum of 4)

UTN

Only required for Resubmissions & Expedited Resubmissions. Enter the UTN of most recent submission.

Primary Diagnosis Code

Type of Bill

Date of Service

FACILITY INFORMATION

Facility Name

PTAN

NPI

Region

Note: **Facility information should be the Hospital Outpatient Department information.**

Fax Number

Note: **If submitting by fax, fax number is required. The fax number must be the fax number of the Hospital Outpatient Department.** *If submitting by mail or esMD, fax number is optional. If you want to also receive the decision letter via fax, provide a fax number. A decision letter will be sent by mail to the provider address on file.*

BENEFICIARY INFORMATION (only one beneficiary per form)

Beneficiary Name

Medicare ID

ATTENDING PHYSICIAN INFORMATION

Physician Name

NPI

REQUESTOR INFORMATION

Requestor Name

Phone Number

Date

Email

FOR OFFICE USE ONLY

Fax to: 1.615.782.4486

Mail to: CGS
PO Box 20203
Nashville, TN 37202

For additional information, please visit our website at: https://www.cgsmedicare.com/parta/mr/opd.html

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Please answer and follow the instructions for each question below.

QUESTIONS

Q1. Is the requested procedure cosmetic (treatment of asymptomatic varicosities, treatment of telangiectases, and/or sclerotherapy for cosmetic purposes)? **Yes** ☐ **No** ☐

Note: If answer is Yes, the procedure is not considered medically necessary.

Comments:

Q2. Is the requested procedure to treat varicose veins/venous insufficiency? **Yes** ☐ **No** ☐

Note: If answer is No, the procedure is not considered medically necessary.

Comments:

Q3. Does the beneficiary have one or more of the following conditions? **Yes** ☐ **No** ☐

- Spider veins or Superficial Telangiectasia
- Patients with an inability to tolerate compressive bandages or stockings
- Patients with severe distal arterial occlusive disease
- Patients in whom there is evidence of obliteration of deep venous system or acute deep venous thrombosis
- Patients with an allergy to the sclerosant
- Pregnancy
- Klippel-Trenaunay Syndrome or other congenital venous abnormalities
- Advanced generalized systemic disease that limits quality-of-life improvements expected following venous intervention

Note: If answer is Yes, the procedure is not considered medically necessary.

Comments:

Q4. Is the requested procedure for one of the following? **Yes** ☐ **No** ☐

- Non-compressive sclerotherapy
- Recanalization of the vein or failure of a vein closure without recurrent signs or symptomsPlease

Note: If answer is No, the procedure is not considered medically necessary.

Comments:

Q5. Have conservative treatments been attempted? **Yes** ☐ **No** ☐

- Oral venoactive drugs
- Weight reduction
- Daily exercise plan
- Periodic leg elevation
- Compressive therapy with the use of surgical grade compression stockings (minimum 20-30 mmHg)
- Other

Note: If answer is No, the procedure is not considered medically necessary.

Comments:

Note: Attach supporting documentation for condition and associated symptoms, rationale for treatment procedure, etc. and/or comment.

DOCUMENTATION

Condition and Associated Symptoms/ Rationale for Treatment Procedure

