HealthPartners®

Prior Authorization for Varicose Vein Procedures of the lower extremities

Fax completed forms to **(952)853-8713.** Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned. **Submit clinical documentation** to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request.

Member information

First Name _____ MI _____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering provider information

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Procedural provider information ☐ *check box if same as **Ordering Provider Information** above*

Provider first name _____ Provider last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility site for procedure or surgery

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*
***For outcome notification*

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Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed.

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Proposed date of procedure _____ or ☐ TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ yes ☐ no

Clinical reason for urgency (not scheduling issues) _____

Endovenous thermal or non-thermal ablation procedures:

Endovenous thermal or non-thermal ablation procedures are limited to a maximum of one treatment session per affected leg within a six-month period when medical criteria are met.

Primary Procedure (CPT) code: _____

Description/Location (Right, Left, Bilateral): _____

Vein Being Treated: _____

Secondary Procedure (CPT) code: _____

Description/Location (Right, Left, Bilateral): _____

Vein Being Treated: _____

Previous Vein Treatment(s) and Dates: _____

_____

Endovenous Chemical Ablation (e.g. liquid or foam sclerotherapy):

Endovenous chemical ablation (e.g. liquid or foam sclerotherapy) is limited to a maximum of two treatment sessions per affected leg within a six-month period when medical criteria are met. The sclerosing agent itself is included as part of the procedure and will not be reimbursed separately.

Primary Procedure (CPT) code: _____

Description/Location (Right, Left, Bilateral): _____

Vein Being Treated: _____

Number of Sessions Requested: _____

Previous Vein Treatment(s) and Dates: _____

_____

Please submit clinical documentation to support your request, including duplex ultrasound report results with interpretation, clear description of the intended treatment plan, applicable procedure (CPT) codes for the planned interventions, and detailed location of treatment.