

Prior Authorization Request Form		Treatment of Varicose Veins/Venous Insufficiency	
BSC Fax: (844) 807-8997		BSC Mail: P.O. Box 629005 El Dorado Hills, CA 95762-9005	
Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for both medical and pharmacy authorizations. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.			
Notice: BSC has a 5 Business Day turn-around time on all Prior Authorization Requests. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.			
Provider Information		Patient Information	
Referring/Prescribing Physician: <input type="checkbox"/> PCP <input type="checkbox"/> Specialist* Name: *Please identify SPECIALTY:		Patient's Name: Birth Date: Blue Shield ID Number:	
Servicing Provider: <input type="checkbox"/> MD <input type="checkbox"/> Vendor <input type="checkbox"/> Lab <input type="checkbox"/> Facility <input type="checkbox"/> Other Name: Address: Tax ID Number: NPI:		Place of Service	
Office Information: Contact: Phone: () Fax: ()		<input type="checkbox"/> Freestanding Ambulatory Surgery Center <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Inpatient Hospital Care <input type="checkbox"/> Long Term Care <input type="checkbox"/> Outpatient Hospital Care <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (explain): Anticipated Date of Service:	
Please enter all codes requested; "by report" codes must have a description of why the code is being used			
ICD-10 PRIMARY DX CODE:			
ICD-10 ADDITIONAL DX CODE(S):			
CPT/HCPCS CODE(S):			
PATIENT CLINICAL INFORMATION			
Please provide the following documentation: <ul style="list-style-type: none"> • History and physical and/or consultation notes including: <ul style="list-style-type: none"> ○ All prior varicose vein treatments to date and response (including conservative management) ○ Each leg and each vein to be treated ○ Reason for varicose vein treatment ○ Type of treatment/procedure requested for each vein in each leg ○ Copy of all Doppler and/or Duplex ultrasounds documenting reflux within the last three months ○ If all veins in the same leg currently needing treatment are not planned to be done on the same date of service, documentation of why that cannot be done ○ For additional treatments not done on the original date of service, documentation why they were not treated initially and/or why they need treatment now 			

For questions: Call BSC Medical Care Solutions	Phone Number: 1-800-541-6652
<small>This facsimile transmission may contain protected and privileged, highly confidential medical, Personal and Health Information (PHI) and/or legal information. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient of this material, you may not use, publish, discuss, disseminate or otherwise distribute it. If you are not the intended recipient, or if you have received this transmission in error, please notify the sender immediately and confidentially destroy the information that faxed in error. Thank you for your help in maintaining appropriate confidentiality.</small>	