



# BlueCross BlueShield of Kansas City

**Prior Authorization/Predetermination  
Varicose Vein Treatment**

**An Independent Licensee of the  
Blue Cross and Blue Shield Association**

Please **fax** completed forms to **(816) 502-4910**  
If you have any questions please call (816) 395-3989

Patient's Name	Physician's Name	
BCBSKC ID (NOT SS#):	Date of Service	
BCBSKC 8-digit Provider # or NPI#	Facility	
Contact Name	Contact Fax No.	Contact Phone No.

Varicose Vein Treatment may be considered **medically necessary** for some veins **>4mm**.  
**Please fill out a separate line for each vein for which you are requesting treatment.**

ICD-9 Codes \_\_\_\_\_ CPT or HCPCS Codes: \_\_\_\_\_

**Check all that apply:**

Symptoms:  Pain  Swelling  Itching  Burning  Hemorrhage of superficial veins  
 Leg Ulcers/Size/Duration: \_\_\_\_\_ Associated w/ Perforator: \_\_\_\_\_  
 Conservative Tx:  Compression Stockings  NSAIDS  Other \_\_\_\_\_  
 How long have conservative measures been tried? \_\_\_\_\_  
 Do symptoms significantly interfere with ADLs?  Yes  No \_\_\_\_\_ How? \_\_\_\_\_  
 Pt has had previous endovenous ablation to the  Right GSV/SSV  Left GSV/SSV \_\_\_\_\_ Date \_\_\_\_\_  
 Pts  Right  Left truncal veins are without reflux and disease.

**EXAMPLE:**

Procedure	Left/Right	Vein	Size(mm)	Reflux?	Seconds?	Tributary?	Perforator?	# TxS Sclero
36478	R	GSV	5.8mm	Yes	1.2	N/A	N/A	N/A
36471	L	Tribs	4.3-5.7	Yes	0.9	Yes	N/A	3

Procedure	Left/Right	Vein	Size(mm)	Reflux?	Seconds?	Tributary?	Perforator?	# TxS Sclero

Please fax **clinical documentation** with this form to fax # (816) 502-4910.

Please allow two (2) business days from date of receipt of all necessary information for determination.  
Duplicate submissions slow the process.

All patient information is strictly confidential.  
**Incomplete forms will be returned.**