Ablative and Surgical Treatment for Venous Insufficiency

Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Purpose of this form

You can use this form to initiate your precertification request. The form will also help you know what supporting documentation is needed for GEHA to review your request.

How to complete the form

We recommend reviewing **GEHA's coverage for Ablative and Surgical Treatment for Venous Insufficiency** completing this form. You can find our coverage policies at **Provider resources**. These will allow you to see the criteria used to determine medical necessity and procedures that are not allowable.

For us to review your request properly and to avoid delay, you must complete all sections of the form and provide the necessary supporting documentation. If you have questions about the form or need help, you can speak with a surgical specialist at 800.821.6136, ext. 3100.

After you have completed the form

Our reviews are completed within 15 days from the time that we receive complete information. Please allow for this time when scheduling the procedure. We are not able to consider a request "urgent" unless waiting the regular time limit for authorization could seriously jeopardize a patient's life, health or ability to regain maximum function.

GEHA

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Refer to the back of the patient's ID card under the heading Prior Authorization for the appropriate contact information.

Date of request: _____ Anticipated service date: _____

Patient name: _____ Phone: _____

Preferred pronouns: _____ (optional)

ID number: _____ Date of birth: _____

Member address: _____

_____

Physician: _____

Tax ID: _____

Address: _____

_____

Contact: _____

Phone: _____ Ext. _____ Fax: _____

DX: _____ ICD-10 code: _____

List all proposed CPT/procedure codes: _____

Please specify for each code what vein is being requested and if Bilateral, Right or Left: _____

_____

IMPORTANT: In addition to this form, submit:

__ Complete history and physical

__ Pre-operative examination with most recent Doppler/duplex scanning reports that include reflux and vein diameter measurements; Post-procedure Doppler report if applicable.

__ Documentation of conservative and adjunctive measures, including duration and outcome.

__ Activities the member must modify or cannot perform due to varicose vein conditions.

Submit completed form and supporting documents to:

GEHA
P.O. Box 21542
Eagan MN 55121

Fax: 816.257.3255 or
Secure email:
caremanagementsurgery@geha.com

Questions: Call GEHA at 800.821.6136, ext. 3100.

All benefit payments are subject to review for any applicable deductibles, coinsurance, maximums, medical necessity and patient eligibility on the date that the service is provided, or the supply delivered.

GEHA®

Procedure requested: 36475, 36476, 36478, 36479, 37765, 37766 and 37799				
GSV Location	**RT**	**LT**	**Quantity**	**Anticipated service date**
Prox Thigh				
Mid Thigh				
Dist Thigh				
Prox Calf				
Mid Calf				
Dist Calf				
AASV				
PASV				
Duplicate				
Perforator				

SSV Location	**RT**	**LT**	**Quantity**	**Anticipated service date**
Prox Calf				
Mid Calf				
Dist Calf				