Innovative Care Management

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Healthcare savings and satisfaction through innovation and respect.

Varicose Vein Treatment

Please complete and FAX this questionnaire with the following clinical information to 503-654-8570:

1. Most recent **History & Physical**.
2. Most recent **office visit note(s)** documenting symptoms and conservative therapy.
3. Most recent **imaging reports**, to include a duplex ultrasound report with interpretation.
4. Clear description of the intended **treatment plan**, applicable **procedure (CPT) codes** for the planned interventions, and detailed **location of treatment**.

Note: Please do not resend clinical if already submitted by separate fax for the primary procedure.

Patient Name: ______________________________ DOB: ____________________

Employer/Plan Name: _________________________ Plan ID: __________________

Submitted By: ____________________ Phone: _____________ Fax: _____________

Physician: ____________________ Phone: _____________ Fax: _____________

Facility: ____________________ Phone: _____________ Fax: _____________

Right Leg

Scheduled On: ____________________

Diagnosis Code(s): ____________________

Procedure Code(s): ____________________

- ☐ 36475, Radiofrequency ablation
- ☐ 36476, Radiofrequency ablation, add'l vein
- ☐ 37766, Stab phlebectomy
- ☐ 37760, Ligation
- ☐ 36471, Ultrasound, Sclerotherapy
- ☐ Other (list procedure/code): __________

Previous Treatment Date(s): ____________

Sessions needed: ____________________

Date(s) of Service: ____________________

Are services being performed together as one procedure: ____________________

Left Leg

Scheduled On: ____________________

Diagnosis Code(s): ____________________

Procedure Code(s): ____________________

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Revision: November 2020