Authorization Request Form - Part 2

Venous Duplex Scan & Venous Reflux Testing

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Peripheral Venous Disease: Venous Duplex Scan, Venous Reflux Testing**

Question 1

Which of the following limb symptoms or findings were documented at the most recent encounter?

- ☐ Heaviness
- ☐ Itching
- ☐ Swelling or edema
- ☐ Pain, aching, or throbbing
- ☐ Skin discoloration
- ☐ Hair loss
- ☐ Skin ulcers
- ☐ Dry skin
- ☐ Varicose veins
- ☐ Superficial thrombophlebitis
- ☐ None of the above

Question 2

Does the patient have any of the following history findings or risk factors?

- ☐ Family history of peripheral venous disease (e.g., lower extremity vein disease, deep vein thrombosis, superficial thrombophlebitis, lower extremity varicose veins)
- ☐ The patient is on hormone therapy (e.g., oral contraceptive therapy, HRT)
- ☐ History of deep vein thrombosis
- ☐ History of malignancy (i.e., solid tumors)
- ☐ The patient is morbidly obese
- ☐ The patient is or has previously been pregnant
- ☐ The patient frequently sits or stands for long periods
- ☐ None of the above

Fill out the following section ONLY if submitting for any of the following: **Stroke: Venous Reflux Testing**

Question 1

Does the patient have any of the following risk non-indications or risk factors?

- ☐ Unable to stand for the duration of the procedure
- ☐ Not a candidate for interventions that reflux testing would reveal (e.g., morbid obesity)
- ☐ Skin ulcers without suspected venous insufficiency
- ☐ Acute, severe swelling or pain of the lower extremity
- ☐ None of the above

Authorization Request Form - Part 2

Carotid Duplex Ultrasound (Doppler) & Computerized Tomography (CT) of the Head

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Stroke: Carotid Duplex Ultrasound (Doppler)**

Question 1

Which of the following findings were documented at the most recent encounter?

- ☐ Weakness or numbness of the face, arm, and leg on one side of the body
- ☐ Speech abnormalities
- ☐ Vertigo (a room spinning sensation), dizziness, or staggering
- ☐ Diplopia (double vision) or visual deficits
- ☐ Deafness
- ☐ Crossed symptoms (one side of the face and other side of the body)
- ☐ None of the above

Question 2

Which clinical condition below needs evaluation?

- ◯ The patient has symptoms that may be due to ischemia (TIA or stroke).
- ◯ Follow-up after a carotid revascularization procedure.
- ◯ None of the above

Question 3

What type of follow-up surveillance best describes this request for Carotid Doppler?

- ◯ One month follow-up after a carotid endarterectomy (CEA)
- ◯ Six month follow-up after a carotid endarterectomy (CEA)
- ◯ Annual follow-up after a carotid endarterectomy (CEA)
- ◯ None of the above
- ◯ Not applicable, this request is not for follow-up after a carotid revascularization procedure.

Fill out the following section if submitting for any of the following: **Stroke, Computerized Tomography (CT) of the Head**

Question 1

Which of the following findings were documented at the most recent encounter?

- ☐ Acute neurologic deficits (including cranial nerve dysfunction and ataxia)
- ☐ Suspected stroke
- ☐ Suspected acute intracranial hemorrhage
- ☐ Follow-up of a known intracranial hemorrhage
- ☐ Mental status change
- ☐ None of the above

Authorization Request Form - Part 2

Duplex Ultrasound & Duplex Ultrasound of Aorta and Iliofemoral Arteries

Complete and fax the clinical worksheet immediately following the authorization request fax form, including any substantiating clinical documentation. Your responses enable faster processing of authorization requests and reduces the likelihood we may require you to submit additional clinical documentation to complete our review.

Please fill in each question option completely ⬭ → ⬬

Patient Information

First name	Last name
Member ID	Date of birth (MM/DD/YYYY)

Fill out the following section if submitting for any of the following: **Aortic Disease: Duplex Ultrasound**

Question 1

Is this a request for screening?

◯ Yes ◯ No

Question 2

If this is a request for screening, which of the following scenarios apply to the patient?

- ☐ 65 to 75 years of age and a history of tobacco use
- ☐ 75 years or older and a history of tobacco use and in otherwise good health who have not previously received a screening ultrasound examination
- ☐ 65 to 75 years of age and the patient has first-degree relatives with an abdominal aortic aneurysm
- ☐ 75 years or older, in good health and the patient has first-degree relatives with an abdominal aortic aneurysm
- ☐ None of the above
- ☐ Not applicable. This is not a request for screening.

Question 3

Is this request for follow-up of a known abdominal aortic aneurysm (AAA)?

◯ Yes ◯ No

Question 4

If this is a follow-up request, which of the following scenarios apply to the patient?

- ☐ Aortic diameter greater than 2.5 cm but less than 3 cm (recommend rescreening after ten years)
- ☐ Aortic diameter between 3.0 and 3.9 cm (recommend surveillance imaging at three year intervals)
- ☐ Aortic diameter between 4.0 and 4.9 cm (recommend surveillance imaging at twelve month intervals)
- ☐ Aortic diameter between 5.0 and 5.4 cm (recommend surveillance at six month intervals)
- ☐ None of the above
- ☐ Not applicable. This is not a follow-up request.

Question 5

Has a physical exam suggested the presence of any of the following findings?

- ☐ Pulsatile mass
- ☐ Peripheral arterial aneurysm
- ☐ None of the above

Fill out the following section if submitting for any of the following: **Aortic Disease: Duplex Ultrasound of Aorta and Iliofemoral Arteries**

Question 1

If this is a request for screening, which of the following scenarios apply to the patient?

- ☐ Buttock or lower extremity claudication
- ☐ Impotence (males)
- ☐ Rest pain or other signs of limb-threatening ischemia
- ☐ Reduced or absent lower extremity pulses
- ☐ Prior diagnosis of aortoiliac arterial occlusive disease
- ☐ None of the above