

Beneficiary Full Name: _____

Sponsor's SSN: _____ - _____ - _____

Date of Birth: _____

Beneficiary State of Residence: _____

Dear Provider,

Please complete and sign this letter of attestation below and return as indicated on the additional information request letter or attach it to your online request. *Requests for **Varithena**® (polidocanol injectable foam) must also include a copy of the Doppler or duplex ultrasound report that documents vein incompetence.*

1. Which of the following is the patient experiencing?

- Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management
- Significant recurrent attacks of superficial phlebitis hemorrhage from a ruptured varix
- Ulceration from venous stasis where incompetent varices are a contributing factor
- None of the above

Periodic elevation of legs for _____ months
Response: _____

Compressive stockings for _____ months.
Response: _____

Other (please specify treatment, duration, and response)

2. Which symptoms are present, if any?

- Aching
- Cramping
- Burning
- Itching
- Swelling during activity or after prolonged standing
- None of the above

4. Is the patient's anatomy amenable to the procedure?
 Yes No

5. List of veins to be treated with Varithena (side, location is mandatory) and reflux measurements for all:

3. Which of the following conservative, non-operative treatments have been attempted?

Please specify for how long and the response.

Mild exercise for _____ months.
Response: _____

Avoidance of prolonged immobility for _____ months.
Response: _____

6. Prior endovenous treatments done, if any, and date performed:

7. If the request for Varithena is within three months of endovenous treatment and sclerotherapy, specify why a 3-month waiting period to determine the success of the endovenous procedure is not needed:

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title: _____

TIN: _____

Physician signature: _____ Date: _____

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L. 104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108

TRICARE is a registered trademark of the Department of Defense, Defense Health Agency. All rights reserved. I HF0521x206 (05/21)