# Aplos Health Plans Preauthorization Request Form

Submit completed forms and clinical information outlined below by fax to **515-328-6597, or** by secure email to **Aplos@innovativecare.com**.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function;** or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim**."

❑ I certify that this request meets the above definition for Urgent processing according to the Department of Labor.

| **Patient Information** | | |
|---|---|---|
| Last Name | First Name | Date of Birth |
| Employer/Plan Name | | Plan ID |
| Address, City, State, Zip | | Phone |
| Subscriber Name (if different than patient) | | Subscriber Relationship |

| **Your Contact Information (Submitted by)** | | |
|---|---|---|
| Name | Phone | Fax |
| Email | | |

| **Provider Information** | |
|---|---|
| Provider Name | Specialty |
| Phone | Fax |
| Provider Primary Address (include suite # if applicable) | NPI |
| | TIN |
| **Facility Information** | |
| Facility | |
| Phone | Fax |
| Facility Address (include suite # if applicable) | NPI |
| | TIN |

**See next page for service details**

| Varicose Vein Treatment Service Request | |
|---|---|
| **Requested Treatment - Left Leg** | **Requested Treatment - Right Leg** |
| Date of Service #1: _____<br>CPT Code(s) and description(s): | Date of Service #1: _____<br>CPT Code(s) and description(s): |
| Date of Service #2: _____<br>CPT Code(s) and description(s): | Date of Service #2: _____<br>CPT Code(s) and description(s): |
| Date of Service #3: _____<br>CPT Code(s) and description(s): | Date of Service #3: _____<br>CPT Code(s) and description(s): |
| Date of Service #4: _____<br>CPT Code(s) and description(s): | Date of Service #4: _____<br>CPT Code(s) and description(s): |
| Diagnosis Code(s): | Diagnosis Code(s): |
| **History - Left Leg** | **History - Right Leg** |
| Previous Treatment and Dates: | Previous Treatment and Dates: |

***Clinical Information***: For Varicose Vein Preauth requests, please include the following information as appropriate:

- ☐ Most recent **History & Physical**
- ☐ Most recent **office visit note(s)** documenting symptoms and conservative therapy as applicable
- ☐ Related i**maging reports**, to include a duplex ultrasound report with interpretation
- ☐ Clear description of the intended **treatment plan**, applicable **procedure (CPT) codes** for the planned interventions, and details pertaining to the **location of treatment**
- ☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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

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