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.**

1. Which of the following is the patient experiencing?
   - ☐ Persistent symptoms interfering with activities of daily living despite 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.
2. Has the patient failed 3 months of conservative treatment?
   - ☐ Yes
   - ☐ No
3. Has the patient had any varicose vein treatments in the last 3 months?
   - ☐ Yes

   Please explain and include date performed:

   - ☐ No
4. Does the request include both truncal and non-truncal veins to be treated?
   - ☐ Yes
   - ☐ No
5. Is Asclera or a compounded sclerosing agent planned for use:
   - ☐ Yes

     Please provide name of agent:

   - ☐ No
6. Are spider veins, spider telangiectasias or reticular veins < 3mm to be treated?
   - ☐ Yes
   - ☐ No
7. List veins to be treated to including their size, reflux measurements and planned treatment/agent for all:

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: _____

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