Common Ground Healthcare Cooperative
PO Box 1630
Brookfield, WI 53008-1630
T: 877.825.9293 | F: 715.221.9749

Port Wine Stain/Abnormal Vascular Lesion Treatment

Prior Authorization Request

Date _____

Member information		
Member name (print)	SMID	Date of birth (month/day/year)
Provider information		
Provider name (print)	Telephone number	Fax number
Place of service: ☐ Ambulatory Surgery Center ☐ Hospital outpatient ☐ Hospital inpatient ☐ Provider's office ☐ Other _____		
Facility where services will be provided (include address if the provider provides services at more than one practice location)		
Procedure information		
Scheduled date of service (month/day/year)	Requested service/procedure	Procedure code(s)
Diagnosis	Diagnosis code(s)	No. of requested sessions

Answer all of the following questions.

The port wine stain/vascular lesion is located on the face and/or neck ..... ☐ Yes ☐ No

If no, location of the port wine stain/vascular lesion _____

Is the member over 18 ..... ☐ Yes ☐ No

For members over 18 years of age, for lesions located on the face and neck, when there is documented:

- Significant physical functional impairment. ..... ☐ Yes ☐ No
- Recurrent bleeding. ..... ☐ Yes ☐ No
- Infection ..... ☐ Yes ☐ No
- Ulceration or obstructed vision ..... ☐ Yes ☐ No

Hemangiomas of infancy, does the member have:

- Association with Kasabach-Merritt syndrome. ..... ☐ Yes ☐ No
- Result in a documented functional impairment. ..... ☐ Yes ☐ No
- Compromising vital structures (e.g. nose, eyes, ears, lips or larynx) ..... ☐ Yes ☐ No
- Symptomatic (e.g. bleeding, painful, ulcerated, prior infection, or pedunculated and symptomatic). ..... ☐ Yes ☐ No

What is the member's treatment plan:

- Sclerosing therapy ..... ☐ Yes ☐ No
- Laser therapy ..... ☐ Yes ☐ No
- Surgical excision ..... ☐ Yes ☐ No
- Cryosurgery/Cryotherapy ..... ☐ Yes ☐ No

- Embolization ☐ Yes ☐ No
- Radiotherapy ☐ Yes ☐ No
- Intralesional steroids ☐ Yes ☐ No

Will this treatment or options be done: ☐ Alone ☐ Combination

Will the member be receiving pulsed dye laser therapy ☐ Yes ☐ No

- Pyogenic granuloma on the face or neck ☐ Yes ☐ No
- Symptomatic scrotal hemangiomas and symptomatic cavernous hemangiomas ☐ Yes ☐ No
- Keloids or other hypertrophic scars which are secondary to an injury or surgical procedure ☐ Yes ☐ No
- Causes significant pain requiring chronic analgesic ☐ Yes ☐ No
- Results in significant functional impairment ☐ Yes ☐ No

Multiple, superficially located glomangiomas in the face and neck, where surgical excision is not practical ☐ Yes ☐ No

Will the member have verrucae (warts) treatment ☐ Yes ☐ No

The member's conventional therapies have been tried and failed: topical chemotherapy, curettage, elecrtrodesiccation and cryotherapy ☐ Yes ☐ No

By signing this form, the provider attests that the above information is accurate and documented in the medical record. CGHC may, at its discretion, request medical records to make a final coverage determination.

_____ _____

Provider signature Date

Pre-service decisions: Initial review is received and a coverage determination is made within fourteen (14) calendar days of receipt of request. The member and/or provider are notified in writing of a denial decision within fourteen (14) calendar days of receipt of the request.

Urgent pre-service decisions: Initial review is received and a coverage determination is made within seventy-two (72) hours of receipt of request.

Mail or fax form to:

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If you have any questions, please contact Customer Service at 1-877-514-2442.