Print Clear form

MASSACHUSETTS

ENDOVENOUS ABLATION PROFESSIONAL PRIVILEGING APPLICATION

Submit your completed, signed, and dated application to:
Provider-Enrollment@bcbsma.com

Please complete the following information if you' re applying for privileges to bill the following procedures codes for radiofrequency and laser ablation services.

Physician information

MD name:		In case of questions about this application, please contact:	
MD license #:		Contact name:	
MD phone #		Contact phone #:	
NPI #:		Contact email:	

Is the physician applicant accredited for Vein Center by the IAC (www.intersocietal.org)? ❒ Yes ❒ No

Modality or modalities requested

❒	36475	Endovenous ablation therapy for incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency, first vein treated	❒ 36478	Endovenous ablation therapy for incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser, first vein treated
❒	36476	Second and subsequent veins treated in a single extremity, each through separate access sites	❒ 36479	Second and subsequent veins treated in a single extremity, each through separate access sites

Site of service information

Please complete for each site of service at which you plan to perform these procedures.

Site of service:	
Site address:	

Facility is accredited for Vein Center by the IAC: ❒ Yes ❒ No

Site of service:	
Site address:	

Facility is accredited for Vein Center by the IAC: ❒ Yes ❒ No

Site of service:	
Site address:	

Facility is accredited for Vein Center by the IAC: ❒ Yes ❒ No

I hereby affirm and represent that all statements, answers, and information in this application are true and complete to the best of my knowledge and belief.

Signature: _____ Date: _____