

Specialty Supplemental Application – Plastic/Cosmetic Surgery & Procedure

IMPORTANT NOTICE

This is a SUPPLEMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

Entity or Last name, first name

PLASTIC/COSMETIC SURGERY & PROCEDURE

ANSWERS A-E

A. Do you perform any of the following plastic surgery procedures? (check all that apply)

- Breast Augmentation
- Burn Repair
- Lower extremity reconstruction
- Scar revision/Congenital defect repair

B. Do you perform any of the following cosmetic procedures? (check all that apply)

Surgery:

Facial Area:

- Facelift
- Eyelid lift
- Rhinoplasty
- Neck Contouring
- Brow lift
- Chin Implants
- Lip enhancements

Breast:

- Augmentation
- Reduction
- Lifts

Body:

- Liposuction
- Tummy Tuck (Abdominoplasty)
- Mommy Makeover
- Male chest reduction
- Skin removal
- Feminine rejuvenation
- Brazilian Butt Lift

Minimally Invasive/non-surgical:

- Injectables/Fillers
- Dermabrasion/microdermabrasion
- Laser removal (hair, tattoo, etc)
- Skin Resurfacing
- Sclerotherapy
- Chemical Peels
- Varicose Vein Treatment/therapy
- Mesotherapy/Lipo-dissolve
- Fat reduction
- Skin Tightening
- Cellulite reduction

C. Are you performing any of these cosmetic procedures in conjunction with a medical practice? Yes No

If Yes, what specialty?

- Dermatology Gynecology Primary Care Other: _____

D. Are any non-physician providers performing any cosmetic or plastic surgery procedures? Yes No

E. For Minimally Invasive/non-surgical procedures, indicate the number of providers that perform these procedures:

- NP/PA _____
- Medical Assistant _____
- RN/LPN _____
- Dermatology Tech _____
- Aesthetician/Esthetician _____
- CRNA/CNM _____
- Physician _____
- Other _____

F. Where do you perform the procedures you have noted? (check all that apply)

- Non-surgical office setting
- Surgical suite within office
- Outpatient surgical facility
- Hospital
- Other: _____

G. If you perform these procedures in your own office or a free-standing facility, other than a hospital,

Do you have admitting privileges at a hospital where the patient can be admitted for an overnight stay or in the case of an emergency? Yes No

Do you have emergency and transfer protocols in writing? Yes No

Are you and your staff ACLS certified? Yes No

Do you have and maintain any resuscitative equipment? Yes No

H. Do you provide anesthesia services? Yes No

If yes, what kind?

- Conscious _____ %
- Local _____ %
- General _____ %
- Other _____ %

If yes, who is providing the anesthesia services? _____

I. Do you provide service for Botox parties? Yes No

If yes, are patients pre-screened prior to participating? Yes No

J. Do you sell pre-packed products for the skin or other areas of the body? Yes No

If yes, what is the annual revenue from these sales? _____

K. Do you sell your own unique products for the skin or other areas of the body? Yes No

If yes, what is the annual revenue from these sales? _____

If yes, do you carry products liability insurance? Yes No

L. Are you performing any procedures that are non-FDA approved, or considered off-label usage? Yes No

If yes, please describe: _____

SIGNATURE

SIGNATURE

Signature

Date