**Prior Authorization Form**

Please Fax To (952)853-8713 For Questions please call (888)-467-0774

# Weight Loss Surgery

| Member and Provider information | |
|---|---|
| Member Name: | Program: |
| Member ID #: | Surgeon: |
| DOB: | Physician Group Tax ID #: |
| Form Completed By: | Phone #: |
| | Fax **#:** |

Requested Procedure:_____
CPT code:_____
Anticipated Date of Surgery _____/_____/_____

1. BMI Qualifications. Please check current BMI Range and qualifications that apply.
Current BMI: _____ (date) ____/_____/_____ Ht _____ Weight _____lbs (date) ____/_____/_____

☐ BMI: ≥40 documented in medical record

☐ BMI 35 to 39.9 with one or more of the following conditions that are not responding to optimal medical management:

☐ Hypertension (consistent blood pressure of 140/90 or greater)

☐ Dyslipidemia with cholesterol LDL greater than or equal to 130 mg/dl.

☐ Diabetes with documented glycosylated hemoglobin levels greater than or equal to 7

☐ Significant obstructive sleep apnea. (i.e. failure of CPAP use or other related sleep apnea treatments).

2. Pre-Operative Participation in Weight Loss Surgery Program phone course program.
Please call 1-800-720-1687 to register the member.
Date referral was made to enroll in phone course: _____/_____/_____
Exempt from Referral – Patient has qualifying BMI with urgent health care condition.
State condition:_____

3. Pre-Operative Behavioral Health and Medical Surgical Clearance.
Psychological evaluation completed ____/_____/_____ by _____
Medical evaluation completed _____/_____/_____ by _____

Please send medical records that support medical necessity and that include information as outlined above.