BlueCare Tennessee

BlueCare℠
TennCare*Select*
CoverKids

Bariatric Surgery Authorization Request Form

Please fax this completed form along with clinical records to: **1-800-292-5311**
OR Submit online authorization requests via Availity® any time day or night.*

Please type/print legibly and fax the completed form to the above number
or attach it within Availity when submitting authorization via the web.
Thank you for your assistance.

Contact's Name: _____ **Phone:** _____ **Fax:** _____

Date of Request: ____/____/____

Member Information

Member Name: _____ DOB: ____/____/____ Member ID#: _____

Member Telephone: (Home) _____ (Work) _____ (Cell) _____

To your knowledge, has this member previously had any Bariatric surgical procedure(s)? ☐ Yes ☐ No

If yes, please state the date of the procedure, type of procedure, and other pertinent information:

Procedure(s) Requested: CPT® Code: _____ ICD-10 Diagnosis Code(s): _____

Facility Information

Facility Where Procedure Will be Performed: _____

Facility Address: _____ Facility Phone: _____

Facility NPI # or BlueCross Provider #: _____ Tentative Date of Surgery: ____/____/____

Type of Admission (Outpatient, 23-hour OBS, Inpatient): _____

Bariatric Surgeon Information

Bariatric Surgeon's Name (Printed): _____ Office Phone: _____

Bariatric Surgeon's Address: _____

BlueCross Provider# **OR** NPI #: _____ Provider Fax: _____

Bariatric Surgeon's Signature: _____ **Date:** ____/____/____

I have reviewed this patient's clinical information and recommend that they have the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge, and clinical records substantiating this documentation are available for review, if requested.

*Contact the eBusiness Marketing team for all your Availity registration and training needs
by calling 423-535-5717, option 2 or emailing eBusiness_marketing@bcbst.com.

Part II – Note: This page may be completed by the attending physician/surgeon at the Multidisciplinary Bariatric Surgery program.

Date: _____/_____/_____

Member Information

Member Name: _____ DOB: _____/_____/_____ Member ID#: _____

Member Telephone: (Home) _____ (Work) _____ (Cell) _____

Current weight: Date: _____/_____/_____ Weight: _____ Height: _____ BMI: _____

This patient is a candidate for bariatric surgery if all of the following criteria are met.

- Individual is 18 years of age or older
- Correctable causes for obesity are not identified (e.g., endocrine disorder)
- No current substance abuse
- Demonstrated reliable participation in preoperative, multidisciplinary weight-loss program (e.g., low-calorie diet, supervised exercise, behavior modification)
- Patient has failed to achieve and maintain significant weight loss with nonsurgical treatment
- Patient will be able to adhere to postoperative care (e.g., judged to be committed and able to participate in postoperative requirements)
- Patient is receiving treatment in a multidisciplinary program experienced in obesity surgery that can provide ALL of the following:
  - Surgeons experienced with the procedure
  - Preoperative medical consultation and approval
  - Preoperative psychiatric consultation, with the conclusion that the individual is able and willing to comply with requisite dietary and behavioral modifications following surgery
  - Nutritional counseling
  - Exercise counseling
  - Psychological counseling
  - Support group meetings

☐ **I certify that the patient meets all of the criteria listed above.**

☐ **This patient doesn't meet all of the criteria listed above, but I still believe they are a candidate for bariatric surgery.** Please list which of the above criteria doesn't apply to this patient and explain why you feel this patient is still a candidate for this procedure below:

Please list (or attach a list of) ALL of the member's current diagnoses and relevant past medical history:

If the member's BMI is 30.0 to 39.9, please list (or attach a list of) pertinent labs, DME (C-Pap, etc.), tests or diagnoses required to support this request for bariatric surgery. See MCG policy definitions for obesity severity.

Attesting Physician Information

Attesting Physician's Name (Printed): _____ BlueCross Provider #: _____

Attesting Physician's Address: _____ Phone: _____

I attest that the information contained above is correct, to the best of my knowledge, and those clinical records substantiating this documentation are available for review, if requested.

Part III – Optional. This form is used when requesting SUBSEQUENT surgery for revision, reversal or correction of prior bariatric surgery — not for initial procedures. The revision or correction may NOT be an investigational procedure.

Member Information

Member Name: _____ DOB: ____/____/____ Member ID#: _____

Member Telephone: (Home) _____ (Work) _____ (Cell) _____

Check the appropriate option below:

☐ Option 1 — Patient is requesting conversion from an initial procedure to a different type of procedure.

☐ Option 2 — Patient requires either correction (revision) of the previous surgical procedure or reversal of the previous surgical procedure.

OPTION 1 Requirements: Subsequent surgical procedure is indicated with ALL the following:

■ The patient is requesting conversion from the initial surgical procedure to a different type of gastric restrictive procedure. ■ The requested procedure is not an investigational procedure. ■ The request is two years or more since the initial surgery. ■ Weight loss is less than 50% of initial procedure pre-operative excess body weight. ■ Weight remains at least 30% over ideal body weight (using standard tables for adult ranges from the National Heart, Lung and Blood Institute). ■ Current substance abuse is not identified.

Please attach the pertinent records to document details of the initial surgery.

What was the initial surgery, and when was it completed? _____

What was preoperative weight and on what date? Preoperative Weight: _____ Date: ____/____/____

What was the lowest weight achieved with initial surgery? Weight: _____ Date: ____/____/____

Is there any current substance abuse? ☐ Yes ☐ No

Is this patient is receiving treatment in a multidisciplinary program experienced in obesity surgery that can provide ALL of the following?

■ Surgeons experienced with the procedure ■ Preoperative medical consultation and approval ■ Preoperative psychiatric consultation, with the conclusion that the individual is able and willing to comply with requisite dietary and behavioral modifications following surgery ■ Nutritional counseling ■ Exercise counseling ■ Psychological counseling ■ Support group meetings

Do all the conditions apply? Please check response: ☐ Yes ☐ No

If No, please explain: _____

OPTION 2 Requirements: If the member requires a **correction (revision) or reversal** of the initial surgery, there must be a physician-documented complication related to the original surgery.

What is the complication? Please state and attach pertinent objective imaging reports.

By signing this document, I attest that the information contained above is correct, to the best of my knowledge, and clinical records substantiating this documentation are available for review, if requested.

Provider Information

Provider's Name (Printed): _____ BlueCross Provider #: _____

Provider's Signature: _____ Phone: _____