



NOT ALL CONTRACTS INCLUDE OBESITY SURGERY BENEFITS. PLEASE VERIFY BENEFITS PRIOR TO SUBMITTING THIS FORM.

Commercial Utilization Management Bariatric Surgery Authorization Request Form

Date: ____/____/____

Part I – Section 1: General Information

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

Member Phone Number: _____

To your knowledge, has this member previously had any bariatric surgical procedure(s)? YES NO

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

Procedure(s) requested: _____

CPT code: _____ ICD-10 diagnosis code(s): _____

Section 2: Provider/Facility Information

Facility: _____ Phone: _____ Fax: _____

Facility Address: _____ Facility NPI # or
Provider ID #: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone: _____ Fax: _____

Tentative date of surgery: ____/____/____

Type of admission (outpatient, 23-hour OBS, inpatient): _____

Bariatric Surgeon's Name: _____ Phone: _____ Fax: _____

Bariatric Surgeon's Address: _____ Surgeon NPI # or
Provider ID #: _____

City: _____ State: _____ Zip: _____

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

I have reviewed this patient's clinical information and recommend the requested bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge. By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Date: ____/____/____

Part II - NOTE: This page may be completed by attending physician/surgeon at Multidisciplinary Bariatric Surgery program.

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

Member Phone Number: _____

Current Weight: _____ Height: _____ BMI: _____

Patient is candidate for bariatric surgery because they meet the following guidelines:

Select all that apply:

- Individual is 13 years of age or older
- Correctable causes for obesity are not identified (e.g., endocrine disorder)
- No current substance abuse
- Patient has failed to achieve and maintain significant weight loss with non-surgical 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:
 - › Preoperative medical consultation
 - › Preoperative mental health consultation, with the conclusion that there are no current untreated eating disorders or psychiatric conditions, and patient is able and willing to adhere to post-op care requirements.
 - › Nutritional counseling
 - › Patient support programs

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 34.9, please list (or attach a list) pertinent labs, DME (C-Pap, etc.), tests or diagnoses required to support this request for bariatric surgery. See policy definitions for obesity severity:

Attesting Physician Information

Attesting Physician's Name (Printed): _____

Attesting Physician's Address: _____

City: _____ State: _____ ZIP: _____

BlueCross Provider #: _____ Phone: _____

I attest that the information contained above is correct, to the best of my knowledge.

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

Member Phone Number: _____

Current Weight: _____ Height: _____ BMI: _____

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 one year or more since the initial surgery
- › Weight loss is less than 50% of initial procedure pre-operative excess body weight or excessive weight regain one year or longer after prior bariatric surgery
- › 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?

- › Preoperative medical consultation
- › Preoperative mental health consultation, with the conclusion that there are no current untreated eating disorders or psychiatric conditions, and patient is able and willing to adhere to post-op care requirements
- › Nutritional counseling
- › Patient support programs

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 imaging reports.

By signing this document, I attest that the information contained above is correct, to the best of my knowledge.

Provider Information

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

Provider's Signature: _____ Phone: _____

Please complete this form and submit it as an attachment through one of the following options. Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call (423) 535-5717, option 2, or contact your eBusiness Network Manager.