HealthPartners®

Prior Authorization Form for Weight Loss Surgery

Request Type: *PN ☐ or **PA ☐

Fax completed forms to **(952)853-8713.** Call Utilization Management (UM) at **(952)883-6333** with questions. Form must be submitted prior to scheduling. Incomplete forms will be returned. **Submit clinical documentation** to support your request. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your prior authorization request

Member information

First Name _____ MI ____ Last Name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First Name _____ Last Name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Ordering physician information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Procedural physician information

☐ *check box if same as **Ordering Physician Information** above*

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic City _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility site for procedure or surgery

Facility name _____

Facility street address _____

Facility City _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____

Phone* _____ Fax** _____

**Confidential voicemail required*

***For outcome notification*

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Procedure or surgery

Only include codes requiring prior authorization; other codes will not be addressed.

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Procedure codes (s) _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

Procedure(s) or surgery description _____

_____

Proposed date of procedure _____ or ☐ TBD

Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ Yes ☐ No

Clinical reason for urgency (not scheduling issues) _____

*PN: Prior Notification: Benefit determination for Designated Providers only. No supporting documentation required.
**PA: Prior Authorization: Health Plan coverage determination for Non-designated providers. Supporting documentation required.
BMI qualifications:

Initial Presentation BMI: _____ (date) _____ Ht _____ Weight _____ lbs (date) _____

☐ BMI ≥40 at initial presentation or

☐ BMI ≥35 at initial presentation with at least one of the following associated health conditions:
- ☐ High blood pressure requiring medical management or documentation of blood pressure greater than 140/90 mm/Hg on multiple, separate dates
- ☐ Dyslipidemia requiring medical management or documentation of LDL level greater than or equal to 130 mg/dl
- ☐ Clinically significant obstructive sleep apnea (OSA) requiring medical management or documentation of OSA confirmed by a sleep specialist following a home sleep study or polysomnography
- ☐ Diabetes requiring medical management or documentation of diabetes confirmed by standard testing
- ☐ Evidence of non-alcoholic fatty liver disease (NAFLD) or nonalcoholic steatohepatitis (NASH) confirmed via physical exam, blood tests, and imaging
- ☐ Pseudotumor cerebri (a condition in which the pressure around the brain increases, causing headaches and vision problems), or

☐ BMI ≥30 but less than 35 at initial presentation, with type 2 diabetes mellitus, and both of the following:
- ☐ Requiring glucose-lowering drug management (e.g., oral and/or injectable medications), and
- ☐ Documentation of a glycosylated hemoglobin (HgbA1c) level at or above 8%.

Pre-Operative Participation in HealthPartners Weight Loss Surgery program phone course. Please call 1-800-720-1687 to enroll the member.

☐ A Referral to HealthPartners Weight Loss Surgery program phone course has been made.
Date referral was made to phone course: _____

☐ Exempt from Referral – Member has qualifying BMI with urgent health care condition.
State condition: _____

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Pre-Operative Behavioral Health and Medical Surgical Clearance.

☐ Psychological evaluation and surgical clearance.

Psychological evaluation was done on _____ by _____

☐ Medical evaluation and surgical clearance.

Medical evaluation was done on _____ by _____

The information is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or treating practitioner signature: _____ Date: _____

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