Bariatric Pre-Authorization

Patient information

Date of request: _____ Patient phone:

Patient name: _____ _____ _____
[First name] [Middle initial] [Last name]

Patient ID: _____ Date of birth: _____ Gender: ☐ M ☐ F

Member name: _____ _____ _____
[First name] [Middle initial] [Last name]

Relationship to the patient? ☐ Self ☐ Spouse ☐ Dependent

Is there other coverage? ☐ Yes ☐ No

If yes, name of the other insurance carrier: _____

Physician information

Name: _____ _____ _____
[First name] [Middle initial] [Last name]

TIN: _____

Office street address: _____

City: _____ State: _____ ZIP: _____

Contact person: _____ _____ _____
[First name] [Middle initial] [Last name]

Physician phone: _____ Ext: _____ Fax: _____

Facility information

Name: _____

Street address: _____

City: _____ State: _____ ZIP: _____

FTIN: _____ NPI: _____

Requested procedure(s) CPT: _____ _____ _____ _____ _____

Diagnosis codes: _____ _____ Proposed surgery date: _____

Clinical information required for review

1. Patient must be 18 years or older. GEHA does not offer any benefit or authorize bariatric surgeries for patients 18 or under.
2. Documentation of participation in a 6-month weight-reduction program.

3. If this is a revision/modification to a bariatric procedure, documentation with clear explanation of the circumstances as to why the procedure failed, the member's current weight, height and BMI and the results of any diagnostic tests or studies performed.
   Height: ____ ft. ____ in. **Weight:** _____ **BMI:** _____
   If the patient's BMI is between 35.0 and 40.0, please be sure to include documentation of treatment/management of the member's comorbid conditions, e.g. medications, c-pap, etc.
4. List current medication(s): _____
   _____
5. Clinical records that support a body mass index (BMI) of 40 or greater, or a BMI of 35-40 when there is at least one co-morbidity related to obesity. Applicable co-morbid conditions include the following:
   - Type II diabetes mellitus (by American Diabetes Association diagnostic criteria)
   - Refractory hypertension defined as blood pressure of 140 mmHg systolic and/or 90 mmHg diastolic despite medical treatment with maximal does of three anti-hypertensive medications;
   - Refractory hyperlipidemia defined as unachievable acceptable levels of lipids despite maximal diet and pharmacological therapy;
   - Coronary heart disease, with objective documentation;
   - Clinically significant obstructive sleep apnea defined by an AHI ≥ 50;
   - Severe arthopathy of the spine and/or weight-bearing joints (when obesity prohibits appropriate surgical management of joint dysfunction treatable but for obesity)
   - Other co-morbid conditions: _____
     _____
     _____
     _____

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of treating physician: _____ Date: _____

Authorization Information (for internal use only) ☐ Electronic submission ☐ Manual submission

Authorization number: _____ Dates of service: _____

☐ Services approved/letter to follow Approval date: _____

☐ Not approved/letter to follow Denial date: _____

Physician: ☐ Par ☐ Non-Par

Facility: ☐ Par ☐ Non-Par

Notes: _____

_____

_____

Instructions

Review of this pre-authorization is pending the completion of this form and supporting documentation. Incomplete forms will be rejected.

IMPORTANT: Please fax completed form and supporting documentation to 816.257.3255.

Questions: Call Customer Service at 800.821.6136. Benefits are subject to the terms and conditions of GEHA's Benefit Plan.

*If unable to fax, please mail pre-authorization request to:
GEHA, PO Box 4665, Independence, MO 64051-4665

Disclaimer

This authorization determines the medical necessity of services requested based upon the information provided. It is NOT a guarantee of payment. It is issued subject to the terms and limitations of your agreement and the member's benefit plan, and subject to the member being eligible at the time services are provided. We reserve the right to deny reimbursement in the event of fraud or misrepresentation or if there is a material change in facts and circumstances that varies from the information that was provided with the original request. The information contained in this form is confidential and only intended for the use of individuals and or entity named above.

Reset all fields