

# Prior Authorization Form

NOTE: Refer to the Provider Manual for additional services requiring Prior Authorization



Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505

## Bariatric Surgery (For Centers of Excellence Programs)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Contract #: \_\_\_\_\_ DOB: \_\_\_\_\_ (Must be 18 years of age or older.)

\*Plan/Product Type:  EPO  HMO  POS  SF-POS  PPO  Medicaid  Medicare

**\*Prior authorization requirements for Bariatric Surgery vary by plan/product. The prior authorization form serves as a tool to collect information that may be required to process the request.**

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Has PCP been notified of request?  Yes  No

Surgeon \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Surgical Evaluation Authorization Number: \_\_\_\_\_

Hospital: \_\_\_\_\_

### Procedure requested (Please check the appropriate box and add CPT Code)

- Roux en Y – CPT Code \_\_\_\_\_
- Laparoscopically Adjustable Banding (with an FDA approved device) – CPT Code \_\_\_\_\_
- Biliopancreatic Diversion with Duodenal Switch – CPT Code \_\_\_\_\_
- Sleeve Gastrectomy (specific criteria must be met) – CPT Code \_\_\_\_\_
- Other – CPT Code \_\_\_\_\_

Note: Coverage is limited to one bariatric procedure per lifetime regardless of insurance carrier at the time of the surgery, unless medically/clinically necessary to correct or reverse complications from a previous bariatric procedure.

### Required

#### Need to include the following for medical review

- Surgeon Evaluation
- Internist Evaluation (in some cases surgeon does medical evaluation also)
- Complete Psychological Evaluation (required for **PriorityMedicaid<sup>SM</sup>** members only)

#### If any of the following medical conditions are present, surgery is contraindicated.

- Pregnancy/lactation
- Severe psychopathology (based on a professional mental health evaluation)
- Medical conditions that make patient a prohibitive risk
- Any disease (e.g. cancer, uremia, liver failure), associated with a likelihood of survival less than 1 year
- Substance abuse including alcohol and other drugs of abuse. Six months of abstinence prior to surgery is required to meet this criterion.
- Tobacco use. At least one month of abstinence prior to surgery is required to meet this criterion. Abstinence is not required prior to surgical evaluation. The surgeon must require at least one month of tobacco abstinence prior to the surgical procedure.

Quit Date: \_\_\_\_\_

**Please note surgery will not be approved unless abstinence criterion prior to surgery date is met.**

Surgery has been scheduled. Please notify Priority Health at above fax numbers.

Surgery Date: \_\_\_\_\_

**\*\*\*ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW\*\*\***

#### For Priority Health Use Only:

- CSM Notified - Inpatient \_\_\_\_\_ Outpatient \_\_\_\_\_
- Prior Authorization Form Copied for Pharmacy \_\_\_\_\_

Last Revision: December 2009