

Prior Authorization Form



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

Fax Form To: 616 942-0024

Bariatric Surgery

Member

Last Name: _____ First Name: _____
Contract #: _____ DOB: _____ (Must be 18 years of age or older.)
Primary Care Physician: _____ Phone: _____ Fax: _____
Has PCP been notified of request? Yes No
*Surgeon _____ Phone: _____ Fax: _____
Contact Name: _____ Phone: _____ Fax: _____
*Is the surgeon who will be performing the surgery a regular member of the American Society for Metabolic & Bariatric Surgery (ASMBS)? Yes No

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 Medicaid 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*****