Prior Authorization for Stage 2 Bariatric Services
Request Form

Online: UHCProvider.com/paan
Phone: 866-604-3267

We regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence and specialty society guidance, as our member benefit plans require care to be medically appropriate. This prior authorization requirement is another step we are taking in support of the Triple Aim to improve care experiences, outcomes and total cost of care for UnitedHealthcare Community Plan members. Stage 2 Bariatric Services is the pre-surgery phase, which includes a required six-month period of evaluation of the member before bariatric surgery is considered. Please complete this form and submit your request online using our Prior Authorization and Notification tool on Link with all supporting clinical data such as progress notes, treatment rendered, tests, lab results and radiology reports. You can access the tool at UHCprovider.com/paan.

Date:_____ Contact person:_____ Phone #: _____

Fax #:_____ Is this a secure fax: □ Yes □ No
Requesting Provider:_____ TIN/NPI: _____

MEMBER INFORMATION

Member name:_____ Member ID:_____ Date of birth: _____
Is the member pregnant**?** □ Yes □ No
Does the member have other insurance? □ Yes □ No
If yes, please specify: □ Medicare Part A □ Medicare Part B
Other insurance name and policy #_____

TYPE OF REQUEST

□ Routine
□ Expedited/Urgent (Must include a physician's order stating that waiting for a decision within a standard timeframe could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.**)**
□ Inpatient □ Outpatient □ Home

PROVIDER AND FACILITY INFORMATION

Rendering Care Provider:_____ TIN/NPI:_____
Address:_____ Fax:_____
Date of service:_____ □ In-network □ Out-of-network

Rendering Care Facility:_____ TIN/NPI_____
Address:_____ Fax: _____
Date of Services:_____ □ In-network □ Out-of-network

If you are an out-of-network provider, will you accept Medicaid/Medicare default rate? □ Yes □ No

CLINICAL INFORMATION

Diagnoses:_____ICD-10 codes: _____

CPT/HCPCS codes: _____

Service description and miscellaneous and/or unlisted codes: _____

Number of visits _____

Start date:_____End date:_____Frequency: _____

Number of previous visits/service description/CPT/HCPCS codes: _____

QUALIFYING QUESTIONS per the Washington Administrative Code 182-531-600(6)

Is the member between ages 18 - 59? ☐Yes ☐No (Members older than 59, may be considered.)

Is the member's BMI 35 or greater? ☐Yes ☐No

Current weight (within last month):

Pounds: _____ Date weighed:_____ Height:_____

If you answer "yes" to any of the following questions and the member successfully completes all stage 2 requirements, the member may qualify for bariatric surgery (stage 3). Stage 3 requires additional prior authorization.

Complete the rest of the form and submit required documentation.

1. Does this member have diabetes?

☐Yes

a. Date of diabetes diagnosis:

b. Which test documents the member has diabetes?_____

☐Hemoglobin A1c 6.5 or higher (Provide a copy of a diagnostic lab value. If newly diagnosed, send two qualifying hemoglobin A1c tests three months apart or one hemoglobin A1c and one of the following tests.):

☐Random glucose > 200mg/Dl (Provide a copy of the diagnostic lab value.)

☐Two-hour oral glucose tolerance test (Provide a copy of the diagnostic lab value and reference range.)

c. What diabetes medications does the member take at this time? _____

☐No

2. Does this member have degenerative joint disease (DJD) of a major weight-bearing joint, and is the member a candidate for replacement if weigh loss is achieved?

☐Yes

a. Provide the following documentation:

☐Diagnostic Imaging report documenting severe DJD; and

☐An orthopedic consult recommending joint replacement as soon as weight loss is achieved

☐No

3. Does this member have a rare comorbid condition for which there is medical evidence bariatric surgery is medically necessary and the benefits of bariatric surgery outweigh the risk of surgical mortality?

☐**Yes**

a. What is the rarecomorbid medical condition?_____

b. Provide documentation that the member has the medical condition and why bariatric surgery is a medically necessarytreatment.

☐ **No**

Please describe and document the medical necessity for bariatric surgery:_____

_____

ADDITIONAL INFORMATION

List all comorbidities related to obesity.

_____

_____

_____

REQUIRED LABS

Attach lab reports with the documentation for comorbidities, including the following:

Hemoglobin A1c from past three months (if not diabetic, from within the past year)
Date: _____

TSH or thyroid studies within the past year - specific which study was completed.
TSH:_____ Other thyroid studies:_____

Recent liver function tests: Check all that apply.

☐AST: ☐ALT: ☐Bilirubin: ☐ALK PHOS:

Recent kidney function tests: Check all that apply.

☐BUN ☐Creatinine ☐eGFR

During the time this member has been your patient, describe the weight loss/diet recommendations and support you have provided them. Why do you think this has not been successful?

_____

_____

Please list previous formal weight loss programs, including approximate dates:

_____

_____

Do you think this member has the ability to maintain the post-operative dietary changes required for success?

☐Yes ☐No

Why or why not? Explain.

_____

REQUIRED RECORDS

Please attach required records in the following order:
1. Diabetes-related labs, if diabetic
2. Diagnostic imaging reports and orthopedic consult, if patient requires joint replacement
3. Detailed history and physical (required for each member requesting bariatric surgery)
4. Other lab work
5. Other supporting and relevant documentation you would like us to review