of Tennessee

NOT ALL CONTRACTS INCLUDE OBESITY SURGERY BENEFITS. PLEASE VERIFY BENEFITS PRIOR TO SUBMITTING THIS FORM.

Commercial Utilization Management
Bariatric Surgery Authorization Request Form

Please fax this completed form along with clinical to: 1-866-558-0789
OR Submit online authorization requests via Availity® anytime day or night*

Please type/print legibly and fax the completed form to the above number or attach within Availity®.

Date: _____/_____/_____

Part I – Section 1: General Information

Member Name:	DOB: _____/_____/_____	Member ID#:
Member telephone: (home)	(work)	(cell)
Contact's Name	Phone:	Fax:

To your knowledge, has this member previously had any Bariatric surgical procedure(s)? ☐ YES ☐ NO

If yes, please state date of procedure, type of procedure, and other pertinent information:

Procedure(s) requested:

CPT code: ICD-10 diagnosis code(s):

Section 2: Provider/Facility Information

Facility:	Phone:	Fax:
Facility Address:		Facility NPI # or Provider ID #:

Tentative date of surgery: _____ Type of admission (outpatient, 23-hour OBS, inpatient): _____

Bariatric Surgeon's Name:	Phone:	Fax:
Bariatric Surgeon's Address:		Surgeon NPI # or Provider ID #:

Bariatric Surgeon's Signature: _____ Date: _____/_____/_____

I have reviewed this patient's clinical information and recommend the requested Bariatric surgery. By signing this documentation, I attest that the information contained above is correct, to the best of my knowledge. By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

* Contact the eBusiness Marketing team for all your Availity registration and training needs by calling 423-535-5717, option 2 or emailing eBusiness_marketing@bcbst.com.

Date: _____/_____/_____

Part II - NOTE: This page may be completed by attending physician/surgeon at Multidisciplinary Bariatric Surgery program.

Member Name:	DOB: _____/_____/_____	Member ID#:
Member telephone: (home)	(work):	(cell):
Current Weight:	Height:	BMI:

Patient is candidate for bariatric surgery as member:

Select all that apply:

☐ **Individual is 13 years of age or older**

☐ **Correctable causes for obesity are not identified (e.g., endocrine disorder)**

☐ **No current substance abuse**

☐ **Patient has failed to achieve and maintain significant weight loss with nonsurgical treatment**

☐ **Patient will be able to adhere to postoperative care (e.g., judged to be committed and able to participate in postoperative requirements)**

☐ **Patient is receiving treatment in a multidisciplinary program experienced in obesity surgery that can provide ALL of the following:**

■ **Preoperative medical consultation** ■ **Preoperative mental health consultation, with the conclusion that there are no current untreated eating disorders or psychiatric conditions, and patient is able and willing to adhere to post-op care requirements.** ■ **Nutritional counseling** ■ **Patient support programs**

Please list (or attach a list of) ALL of the member's current diagnoses and relevant past medical history:

If the member's BMI is 30.0 to 34.9, please list (or attach a list) of pertinent labs, DME (C-Pap, etc.), tests or diagnoses required to support this request for bariatric surgery. See policy definitions for obesity severity:

Attesting Physician Information

Attesting Physician's Name (Printed): _____ **BlueCross Provider #:** _____

Attesting Physician's Address: **Phone:**

I attest that the information contained above is correct, to the best of my knowledge.

PART III – Optional. This form is used when requesting SUBSEQUENT surgery for revision, reversal or correction of prior bariatric surgery. Not for initial procedures.
The revision or correction may NOT be an investigational procedure.

Member Name:	DOB: _____/_____/_____	Member ID#:
Member telephone: (home)	(work):	(cell):
Current Weight:	Height:	BMI:

Check the appropriate option below:

☐ Option 1 — Patient is requesting conversion from an initial procedure to a different type of procedure.

☐ Option 2 — Patient requires either Correction (revision) of the previous surgical procedure or reversal of the previous surgical procedure.

OPTION 1 Requirements: Subsequent surgical procedure is indicated with ALL the following:

- The patient is requesting conversion from the initial surgical procedure to a different type of gastric restrictive procedure.
- The requested procedure is not an investigational procedure. ■ The request is one year or more since the initial surgery ■ Weight loss is less than 50% of initial procedure pre-operative excess body weight or excessive weight regain one year or longer after prior bariatric surgery. ■ Current substance abuse is not identified.

Please attach the pertinent records to document details of the initial surgery.

What was the initial surgery, and when was it completed? _____

What was preoperative weight and on what date? Preoperative Weight: _____ Date: _____/_____/_____

What was the lowest weight achieved with initial surgery? Weight: _____ Date: _____/_____/_____

Is there any current substance abuse? ☐ Yes ☐ No

Is this patient is receiving treatment in a multidisciplinary program experienced in obesity surgery that can provide ALL of the following?

- Preoperative medical consultation ■ Preoperative mental health consultation, with the conclusion that there are no current untreated eating disorders or psychiatric conditions, and patient is able and willing to adhere to post-op care requirements. ■ Nutritional counseling
- Patient support programs

Do all the conditions apply? Please check response: ☐ Yes ☐ No

IF NO, please explain: _____

OPTION 2 Requirements: If the member requires a **correction (revision) or reversal** of the initial surgery, there must be a physician-documented complication related to the original surgery.

What is the complication? Please state and attach pertinent objective imaging reports.

_____

By signing this document, I attest that the information contained above is correct, to the best of my knowledge.

Provider Information

Provider's Name (Printed): _____ Provider #: _____

Provider's Signature: _____ Phone: _____

24PED2670796 (5/24)