



Prior Authorization Stage 3 Bariatric Surgery 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. After completing the pre-surgery phase, stage 2, for bariatric services, please complete all fields in this form for stage 3, the bariatric surgery and submit your request online using our Prior Authorization and Notification tool on Link with all relevant clinical records indicating that the member has completed the required six month pre- surgery, stage 2. You can access the tool at UHCprovider.com/paan.

Please also submit:

- Notes from monthly health care provider visits, as required to review progress
- Notes from dietician/nutritional counseling two times a month for at least six months
- Documentation indicating loss of at least five percent of the member's body weight based on a documented weight at a recent medical appointment in a six-month period of time
- Documentation indicating that member has maintained their weight loss until the time of surgery
- Documentation that the weight loss program was supervised by a licensed medical provider who the member has seen monthly
- Documentation indicating that member has kept a journal of active participation in a medically-structured weight loss regimen
- Bariatric surgeon consultation documentation
- Internist consultation documentation
- Psychosocial evaluation indicating:
 - a. Assessment of mental status; and
 - b. Assessment of the member's ability to comply with the pre-surgery requirements and post-surgery lifestyle and dietary changes needed for a successful surgery

Date: _____ Contact person: _____ Phone #: _____
Fax #: _____ Is this a secure fax number? Yes No
Requesting Provider Name: _____ 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, check type of other insurance:

Medicare Part A or 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 under a standard timeframe could endanger the member's life, health or ability to regain maximum functionality, or would cause serious pain.
- Inpatient Outpatient Home

Servicing Care Provider and Facility Information

Servicing care provider: _____ TIN/NPI: _____

Address: _____ Fax#: _____

Date of service: _____ In-network Out-of-network

Servicing facility: _____ TIN/NPI: _____

Address: _____ In-network Out-of-network

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

Clinical Information

Diagnoses: _____ ICD-10 codes: _____

Required CPT/HCPCS code(s): _____

Miscellaneous and/or unlisted codes description required: _____

Number of visits: _____ Start date: _____ End date: _____

Frequency: _____ Durable Medical Equipment Cost: \$ _____

Number of previous visits/service description/CPT/HCPCS code(s): _____

Confidentiality Notice: The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act. This information is intended for the sole use of the addressee named above. If you are not the intended recipient, you are hereby notified that reading, disseminating, disclosing, distributing, copying, acting upon, or otherwise using the information in this correspondence is prohibited. If you received this information in error, please notify UnitedHealthcare to arrange return of the documents to us or to verify their destruction.