

**Prior Authorization Request for
Bariatric Surgery Evaluation**

Health Tradition Health Plan requires prior authorization for bariatric surgery evaluation.

The following information can be provided by either:

- Completing this form; or
- Submitting a letter of medical necessity/clinical note which includes all the information on this form.

Receiving incomplete information will delay the processing of the request or may result in a denial.

First Name: _____ M.I. _____ Last Name: _____

DOB: _____

Address: _____
street city state zip

Insurance Plan: _____ Insurance Number: _____

BMI: _____ Weight: _____ kg Height: _____ cm

Patient is being referred to: _____
(Include name of practitioner and location of surgery)

Describe and document weight loss attempts and methods including time frame, patient compliance, and the amount of weight loss.

Describe all high-risk comorbidities.

Are there any untreated metabolic cause for obesity, such as adrenal or thyroid disorders? If yes, please describe.

Are there any medical conditions contradicting gastric bypass surgery? If yes, please describe.

List exercise programs, including type and length of programs.

Date member completed a psychological evaluation performed by a licensed psychologist or psychiatrist?
Attach evaluation.

Practitioner: _____ Practitioner e-mail address: _____

Name of person completing form if different from Practitioner: _____