BlueCross BlueShield Minnesota

Bariatric Surgery (Medical Policy IV-19)
Commercial Pre-Authorization (PA) Request Form

Please refer to medical policy criteria on **providers.bluecrossmn.com** for clinical review criteria prior to submission

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross**. Please complete the clinical sections on this form and attach it to your request at **Availity.com** to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-2810.

Patient Information

Will waiting the standard review time seriously jeopardize the life or health of the member or the member's ability to regain maximum function? ☐ Yes ☐ No

Member ID: _____ _____ Group number: _____

Member name: _____ Date of birth: ___ /___ /_____

Member address: _____

Member city/state/zip: _____

Member phone: ____-____-_____

Servicing Provider Information

Contact person: _____ Phone: ____-____-_____

Servicing provider name: _____

Servicing provider ID/NPI number: _____

Servicing provider address: _____

City/state/zip: _____

Servicing provider phone: ____-____-_____ Servicing provider fax: ____-____-_____

Inpatient/Outpatient Facility name: _____ Facility ID:_____

Blue Distinction Center (BDC) for Bariatric Surgery? ☐ No ☐ BDC ☐ BDC+

Ordering Provider Information

Ordering provider name: _____

Ordering provider ID/NPI number: _____

Ordering provider address: _____

City/state/zip: _____

Ordering provider phone: ____-____-_____ Ordering provider fax: ____-____-_____

Services/Procedures/Items Requested

HCPC/CPT Code(s)	HCPC/CPT Code(s) Description	ICD-10 Diagnosis Code(s)	Start Date mm/dd/yy	End Date mm/dd/yy

X21806R05 (01/21)

Please attach all relevant clinical documentation that supports information selected in the form.

Surgical Procedure	**Surgical Procedure** (e.g. open or laparoscopic Roux-en-Y, adjustable gastric banding, open or laparoscopic sleeve gastrectomy, open or laparoscopic biliopancreatic diversion with duodenal switch)**:** Is this a revision or conversion surgery? ☐ Yes ☐ No If, yes, date of original surgery: ___ /___ /_____ If, yes, please supply the specific indication for revision/conversion surgery (choose one): ☐ Treatment of surgical complications or technical failures following the original bariatric surgery (please describe): ☐ Inadequate weight loss following the original surgery (please provide documentation of patient compliance with post-surgical care plan and psychological evaluation for reoperation).

Patient Selection Criteria	Body Mass Index (BMI): _____ Date of measurements: ___ /___ /_____ Height: _____(feet) _____(inches) Weight: _____ ☐ lbs ☐ kg **AND** **One of the following:** ☐ Age 18 years or older; **OR** ☐ Bone age of ≥ 13 years in girls or ≥ 15 years in boys; OR Attainment of 95% of adult height based on estimates of bone age; **AND** ☐ BMI: ≥ 40 kg/m^2 **OR** ☐ BMI 35 <40 kg/m^2 (please check all that apply): ☐ Hypertension refractory to standard drug regimens ☐ Cardiovascular disease ☐ Type 2 diabetes mellitus (HbA_{1C}) of 7 or greater, or requiring medication) ☐ Obstructive sleep apnea requiring continuous positive airway pressure (CPAP) or other related treatment ☐ Obesity – hypoventilation syndrome (OHS) ☐ Pickwickian syndrome (a combination of OSA and OHS) ☐ Nonalcoholic fatty liver disease (NAFLD) ☐ Nonalcoholic steatohepatitis (NASH) ☐ Pseudotumor cerebri **AND** **All of the following:** ☐ Psychological evaluation was completed on: Date: ___ /___ /_____ by _____ (Provider Name and Credentials) ☐ Verification of patient participation in preoperative program: Date: ___ /___ /_____ by _____ (Provider Name and Credentials) ☐ Completion of surgical preparatory program: Date: ___ /___ /_____ by _____(Provider Name and Credentials)

Please attach all relevant clinical documentation that supports information selected in the form.

Description/Additional Information:

Total pages: _____