Weight Loss Surgery Referral Checklist

Please Fax To (952)853-8713   For Questions Call (952)883-6333

Name: ______________________________ **Date of Birth**: ________/________/_________ **HealthPartners ID#**:______________________	**Current BMI**: _______ (date) ____/______/_______ **Ht** _____ **Weight**_____ (date) ____/_____/_______
PN: ___ * PA: ___ **	**Requested Procedure:**______________________ **CPT code**:______________

PROGRAM: ___________________________________ **SURGEON**: ___________________________

Physician Group Tax ID#_______________________________

Person completing this form:__________________________

Phone Number: (______)____________________ **Fax Number**: (______)_____________________

1. BMI Qualifications. *Please check current BMI Range and qualifications that apply.*

a. ☐ **BMI: ≥40 documented in medical record**

b. ☐ **BMI 35 to 39.9 with one or more of the following conditions that are not responding to optimal medical management:**

- ☐ Hypertension (consistent blood pressure of 140/90 or greater)
- ☐ Dyslipidemia with cholesterol LDL greater than or equal to 130 mg/dl.
- ☐ Diabetes with documented glycosylated hemoglobin levels greater than or equal to 7
- ☐ Significant obstructive sleep apnea. (i.e. failure of CPAP use or other related sleep apnea treatments).

2. PRE-Operative Participation in A Call to Change Weight Loss Management program.
Please check and indicate date of referral and anticipated surgical date.

☐ **A Completed Referral to HealthPartners pre-surgical phone course, "A Call to Change", has been made.**

☐ **Date referral was made to "A Call to Change" phone course:** _____/_____/________

- ☐ *For providers with access security to HealthPartners website at:* **:** www.hphealthbehaviorgroup.com/refsys
- ☐ For providers without security access, please call 1-800-720-1687.

☐ **Exempt from Referral –**

- ☐ Patient **has qualifying BMI with urgent health care condition. State condition:**

____________________________________.

☐ **Anticipated Date of Surgery** ______/_______/________

3. PRE-Operative Behavioral Health and Medical Surgical Clearance.
Please complete below with accompanying signatures.

☐ **Psychological evaluation and surgical clearance.**

Psychological evaluation was done ____/_____/______ by ______________________________.

I certify that the patient has been seen and cleared for surgery: ____
(**Signature of Operating Surgeon)**

☐ **Medical evaluation and surgical clearance.**

Medical evaluation was done on _____/_____/_____ by ____________________________.

I certify that the patient has been seen and cleared for surgery: ____
(**Signature of Operating Surgeon)**

*PN: **Prior Notification:** Benefit determination for Designated Providers only. No supporting documentation required.

PA: **Prior Authorization. Health Plan coverage determination for Non-designated providers. Supporting documentation required.