HIGHMARK

Bariatric Surgery Precertification Worksheet

Submission Instructions:
Please print all information.
IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSEDWITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS**.
Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.
Please fax completed form to Clinical Services: **888.236.6321** or **800.670.4862** *(Delaware Only)*

PROVIDER INFORMATION	PATIENT/PROCEDURE INFORMATION
Contact Name: _____	Member Name: _____
Office Phone: _____	Member UMI#: _____
Office Fax: _____	Date of Birth: _____
Provider Name: _____	Member Address: _____
Provider NPI#: _____	_____
Provider Address: _____	Member Phone: _____
_____	ICD-10 Diagnosis Code (Required): _____
Facility Name: _____	Procedure Name: _____
Facility NPI#: _____	Procedure Code (Required): _____
Facility Address: _____	Requested Setting: ❑ Inpatient ❑ Short Procedure
_____	Date of Service: _____

Please answer all questions below:

- Age: _____ Height: _____ Weight: _____ BMI: _____
- Prior history of bariatric surgery? If yes, Date: _____ ❑ Yes ❑ No
- Is this a revision? ❑ Yes ❑ No
- Documentation of one of the following comorbid conditions:
  - Diabetes MellitusType2? ❑ Yes ❑ No
  - Cardiovascular Heart Disease? ❑ Yes ❑ No
  - Hyperlipidemia? ❑ Yes ❑ No
  - Hypertension refractory to concurrent use of 3 anti-hypertensives of different classes? ❑ Yes ❑ No
  - Sleep Apnea (OSA), Obesity-hypoventilation Syndrome (OHS), or Pickwickian Syndrome? ❑ Yes ❑ No
  - Nonalcoholic fatty liver disease or nonalcoholic steatohepatitis? ❑ Yes ❑ No
- Participated in non-surgical treatments and attempts at weight loss have failed? (i.e. weight reduction programs, dietary restrictions and exercise regime.) ❑ Yes ❑ No
- Psychological screening completed (documentation required)? If yes, Date: _____ ❑ Yes ❑ No

Please Note: Requests should be made a minimum of 2 weeks prior to surgery. Member medical information must be current, preferably within the last 6 months.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*

2. Please provide the physician address as it is required for physician notification.

3. Fax the **completed** form and all clinical documentation to **1-888-236-6321**

   Or mail the completed form to: **PAPHM-043B**
   Clinical Services
   120 Fifth Avenue
   Pittsburgh, PA 15222

For a complete list of services requiring authorization, please access the **Authorization Requirements** page on the Highmark Provider Resource Center under Claims, Payment & Reimbursement > Procedure/Service Requiring Prior Authorization or by the following link: https://hwvbcbs.highmarkprc.com/Claims-Payment-Reimbursement/Outpatient-Procedures-Service-Requiring-Prior-Authorization

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