BlueCross BlueShield
Federal Employee Program

Prior Authorization Request Form	*Bariatric Surgery (Benefit)*
Standard Fax Number: 1 (855) 895-3504	**Urgent Fax Number:** 1 (844) 224-0226

Use AuthAccel - Blue Shield's online authorization system - to complete, submit, attach documentation, track status, and receive determinations for medical requests and requests for medications covered under the medical benefit. Visit Provider Connection (www.blueshieldca.com/provider) and click the Authorizations tab to get started.

Notice: The Federal Employee Program has a 15 Calendar Day turn-around time on all Standard Prior Authorization Requests according to the Blue Cross Blue Shield Service Benefit Plan. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

☐ **New Standard Request** ☐ **New Urgent Request**

Important For Urgent Requests: Scheduling issues do not meet the definition of an urgent request. The definition of an urgent request is an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision-making might seriously jeopardize the life or health of the enrollee. ***If there is no MD signature present the request will be processed as a Standard request.***

MD Signature REQUIRED For Urgent Requests Only:

☐ **Modification Or** ☐ **Extension Requests Complete the Section Below:**

Date Last Authorized:	Previous Authorization Number:
MD/NP/PA justification for modification or extension:	

Patient Information:

First Name:	Last Name:
Date of Birth:	ID Number:
Address:	

Referring/Prescribing Provider:

Name:			NPI:	
Street Address + Suite #:			Email address:	
City:	State:	Zip:	Phone:	Fax:
Type of Provider: ☐ PCP ☐ Specialist Type:			Contact Name and Phone Number:	

Servicing/Billing: Provider/Vendor/Lab *If same as Referring/Prescribing Provider Check Here* ☐

Name:			NPI:	
Street Address + Suite #:			Email address:	
City:	State:	Zip:	Phone:	Fax:

Specialist Type:	Contact Name and Phone Number:

If Servicing Provider is billing as part of a Group Contract enter the Group Name and Address:		
Group Name:		NPI:
Street Address + Suite #:		
City:	State:	Zip:

Billing Facility (If Applicable):				
Facility Name:			NPI:	
Street Address + Suite #:				
City:	State:	Zip:	Phone:	Fax:
Contact Name and Phone Number:				

Anticipated Date of Service:	**If Lab, Draw Date:**

Place of Service: (Check One Box Only or If typing replace box with an "X"):

☐ Office	☐ Home	☐ On Campus OP Hosp
☐ Acute Rehab	☐ Hospice	☐ PHP
☐ Ambulance- Air or Water	☐ Independent Clinic	☐ RTC – Psychiatric
☐ Ambulance-Land	☐ Independent Laboratory	☐ RTC – SUD
☐ Ambulatory Surgical Center	☐ Inpatient Hospital	☐ Skilled Nursing Facility
☐ Assisted Living Facility	☐ Intermediate Care Facility	☐ Telehealth
☐ Birthing Center	☐ IOP	☐ Urgent Care Facility
☐ Custodial Care Facility	☐ IP Psychiatric Facility	☐ Other - Please Specify:
☐ End Stage Renal Disease TX	☐ Nursing Facility	
☐ Group Home	☐ Off Campus OP Hosp	

Please enter all codes requested; unlisted codes must have a description.
Please include the quantity for each code requested and if applicable, left, right or bilateral designations.

ICD-10 Code(s):

CPT/HCPC Code(s):

For questions: Call FEP Authorization Requests Phone Number: 1 (800) 633-4581

Please provide the following documentation

History and physical and/or consultation notes including:

Clinical findings

- Primary diagnosis and relevant co-morbidities
- Patient age, height, weight, BMI
- Date of diagnosis of morbid obesity
    - BMI greater than or equal to 40
    - BMI greater than or equal to 35 with one or more co-morbidity
- Documentation of patient's smoking history
- Documentation of substance use disorder, if applicable, to include:
    - Documentation that patient has not been treated for substance use disorder in the 12 months prior to surgery
    - No evidence of substance use disorder during 12 months prior to surgery

Prior treatment

- Documentation of all weight loss attempts in the 12 months prior to surgery date with results
- Documentation of patient participation in a medically-supervised weight loss program, to include nutritional counseling, for **at least 3 months** prior to surgery date.

Consultation

- Psychological clearance by a licensed professional mental health practitioner:
    - Psychological assessment which includes evaluation of patient's ability to understand and adhere to pre- and post-operative program
- Nutritional assessment and nutritional counseling:
    - Provided in the pre-operative phase
    - Includes discussion of pre- and post-operative nutrition, eating and exercise
- Other pertinent multidisciplinary notes or reports (i.e. cardiac or pulmonary clearance notes, etc.)

Rationale

- Planned procedure type. Allowed procedures are:
    - Roux-en-Y gastric bypass
    - Laparoscopic adjustable gastric banding
    - Sleeve gastrectomy
    - Biliopancreatic bypass with duodenal switch

If **repeat procedure** is planned, additional documentation is required:

- Date of initial procedure and discussion of result, including pre- and post-procedure weight
- Documentation that patient meets all of the criteria above **or**
    - Documentation that surgery is needed to treat a complication of a prior morbid obesity surgery
- Documentation that member complied with previously prescribed post-op nutrition and exercise program
- Documentation by patient's medical provider that all pre-surgical requirements have been met

View our Medical Policy online at https://www.fepblue.org/legal/policies-guidelines