blue of california

Prior Authorization Request Form	Bariatric Surgery
Standard Fax Number: 1 (844) 807-8997	**Urgent Fax Number:** 1 (844) 807-8996

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

Notice: Blue Shield of CA has a 5 Business Day turn-around time on all Standard Prior Authorization Requests. 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 ☐ Standing Referral

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 #:				
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:	Tax ID:	NPI:
Street Address + Suite #:		

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	☐ PH
☐ 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 BSC Medical Care Solutions Phone Number: 1-800-541-6652

Please provide the following documentation:

☐ Initial Bariatric Procedure or Revision for Inadequate Weight Loss

- ☐ History and physical and/or consultation notes including prior weight loss attempts and responses, and comorbidities (if needed):
  - ☐ Documentation of failed weight loss by conservative measures in adults (ages 18 and older) in adults with Class 3 Obesity with body mass index (BMI) greater than or equal to 40.0 kg/m2)

    OR

  - ☐ Diagnosis of at least 1 obesity-related comorbid condition with BMI greater than or equal to 35 to 39.9 kg/m2 in adults with Class 2 Obesity

    OR

  - ☐ Diagnosis of type 2 diabetes in individuals with Class 1 obesity with BMI greater than or equal to30 to 34.9 kg/m2

☐ Revision Bariatric Surgery:

- ☐ Documentation of the problem needing correction (history and physical and/or consultation notes including: prior surgery and complications as applicable, indication for surgery, and treatment plan), which may include, but are not limited to:
  - ☐ Staple-line failure or leakage
  - ☐ Obstruction, stricture, erosion, or fistula
  - ☐ Gastroesophageal reflux disease (GERD), based on ambulatory pH probe monitoring, or endoscopic findings of ulcer, strictures, Barrett's esophagus, or esophagitis and failing maximal medical therapy
  - ☐ Pouch enlargement documented by endoscopy and prior successful weight loss
  - ☐ Nonabsorption resulting in hypoglycemia or malnutrition
  - ☐ Weight loss of 20% or more below ideal body weight
  - ☐ Band slippage or herniation that cannot be corrected with manipulation or adjustment

☐ Bariatric Surgery in Adolescents:

- ☐ Documentation requested for Initial Bariatric Procedure in Adults with Obesity
- ☐ Documentation of psychological counseling
- ☐ Documentation of informed consent
- ☐ Documentation that any device used for bariatric surgery is in accordance with the FDA-approved indication for use

☐ Concomitant Hiatal Hernia Repair:

- ☐ Documentation of preoperatively-diagnosed hiatal hernia with indications for surgical repair