# **Microsoft Weight Management Program Physician Recommendation Form**

Premera Blue Cross Logo


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| STEPS FOR OBTAINING PRIOR AUTHORIZATION |
| Eligibility Requirements: Microsoft employees and their covered spouse/domestic partner who are enrolled in a Premera medical or Kaiser Foundation Health Plan of Washington option are eligible for the weight management program benefit if they meet the following criteria: |
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| * Diagnosed as obese {Body Mass Index (BMI) greater than or equal to 30} **OR** * BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:   + Congestive heart failure   + Coronary heart disease   + Depression   + Diabetes   + Hyperlipidemia   + Hypertension |
| Patient Instructions:  * Have your primary care or regular physician complete this form and fax back to Premera.   + Your physician will receive notification of approval into the program. If you do not hear back from them within 15 calendar days of completion, please contact them or Premera directly for status. * Required lab work to confirm cholesterol and glucose readings may also be requested from your physician at this time.  Physician Instructions:  * Fax the back of this completed form to Premera Blue Cross at 800-676-1477.   + A confirmation of approval will be faxed back to you and the weight management program the member selected. * Please contact the member once you have received the program approval. * Prior authorization is valid for 6 months.  Note:  * Weight Management providers are recommended to call Premera at 800-676-1411 to confirm your benefits. * If your recommendation is denied, you will receive a letter explaining the denial and your appeal rights. |  |
| To view the list of approved providers, visit **aka.ms/benefits***.* Click on **Health & Fitness** and then **Weight Management** under **Fitness & Staying Healthy**.  See form on back page. |

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| PATIENT / MEMBER INFORMATION: |

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| Last name: | | | | | | First name: | | | | | | | | | | | M.I.: |
| Premera Blue Cross member ID number (found on your Premera member ID card): | | | | | | | | | Date of birth (m/d/yyyy): | | | | | | | | |
| **\***Selected weight management program: | | | | | | | | | **\***Weight management program address: | | | | | | | | |
| **\*Must be an approved Weight Management Program provider** | | | | | | | | | | | | | | | | | |
| MUST BE COMPLETED BY PATIENT’S PRIMARY CARE PHYSICIAN (PCP) OR REGULAR PHYSICIAN | | | | | | | | | | | | | | | | | |
| Patient’s: | Body mass index (BMI): | | | | Weight (lbs or kg): | | | | | | | Height (inches or feet): | | | | | |
| Patient is diagnosed with the following conditions (check all that apply): | | | | | | | | | | | | |  | | | | |
| Congestive heart failure | | | | | | | Coronary heart disease | | | | | | | | | | |
| Diabetes | | | | | | | Hyperlipidemia | | | | | | | | | | |
| Hypertension | | | | | | | Depression | | | | | | | | | | |
|  | | | | | | |  | | | | | | | | | | |
| The following cholesterol and glucose readings are required prior to enrollment in a weight management program. Please provide the results to the weight management provider: | | | | | | | | | | | | | | | | | |
| HDL | |  | | Triglycerides | | | |  | | HDL/LDL ratio | | | |  | |  | |
| LDL | |  | | Total cholesterol | | | |  | | Fasting glucose | | | |  | |  | |
| **I know of no reason why this patient cannot participate in this program.** | | | | | | | | | | | | | | | | | |
| **Referring provider information:** | | | | | | | | | | | | | | | | | |
| Provider name (printed): | | |  | | | | | | | | | | | | | | |
| Provider address: | | |  | | | | | | | | | | | | | | |
| Tax/NPI ID: | | |  | | | | | | | | | | | | | | |
| Provider phone number: | | |  | | | | | | | | | | | | | | |
| Provider fax number: | | |  | | | | | | | | | | | | | | |
| Provider signature: | | |  | | | | | | | | Date (mm/dd/yyyy): | | | |  | | |
|  | | | | | | | | | | | | | | | | | |
| PROVIDERS: Please fax this completed form to Premera Blue Cross at (800) 676-1477.  Completion of this form is necessary to confirm benefit coverage and eligibility for your patient. | | | | | | | | | | | | | | | | | |
| **NOTICE:** The information on this document contains confidential information intended only for the individual named above and Premera Blue Cross. If the reader of this document is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of the document is strictly prohibited. If you have received this document in error, please notify us immediately by telephone at 800-676-1411. | | | | | | | | | | | | | | | | | |

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Please call customer service 8 0 0 7 2 2 1 4 7 1 for assistance in your language.

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