PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Bariatric Surgery Assessment Form: Patient Referral Information

Demographic information

Primary care physician _____ Date of request _____

Address _____ Phone number _____

_____ NPI _____

Member name _____ Premera contract number _____

Address _____ Phone number _____

_____ Date of birth _____

Sex: ☐ Male ☐ Female • Height:_____ • Weight:_____lbs. • BMI _____

Comorbidities (Check all that apply.)

☐ Atherosclerotic heart disease	☐ Hyperlipidemia	List other(s):
☐ Congestive heart failure	☐ Hypertension	_____
☐ Coronary artery disease	☐ Sleep apnea	_____
☐ Degenerative joint disease	☐ Stroke	_____
☐ Diabetes mellitus		_____
		_____

Fax the following information to Premera Blue Cross at 866-809-1370:

1. Completed *Physician-Supervised Weight Loss Program Documentation* forms or other documentation completed during physician-supervised office visits for six consecutive months over the last two years. A minimum of three office visits is required in the first 90 days. A minimum of two visits is required in the subsequent three months; the final visit must occur at the end of the six-month period or within 30 days of its end. All of the elements listed below must be documented for a minimum of **five** visits over **six** months; more frequent documentation should occur if clinical circumstances dictate.
2. Information from a psychological evaluation that has been performed as a pre-surgical assessment. Providers should call Premera Blue Cross Care Management at 855-339-8127 to request a referral for the psychological evaluation.
3. Name of the bariatric surgery facility at which the initial consultation is to be performed:

   _____
4. Name of the referral surgeon: _____
5. This form completed, and signed on the next page by the physician.

Member name_____ Premera contract number _____

I have discussed this procedure with my patient and we both have a good understanding of the risks involved and reasonable expectations that the patient will be compliant with all postsurgical requirements.

Physician signature

Date