

Weight Loss Surgery Referral Checklist

Please Fax To (952)853-8713 For Questions Call (952)883-6333

Name: _____ Date of Birth: ____/____/____ HealthPartners ID#: _____	Current BMI: _____ (date) ____/____/____ Ht _____ Weight _____ (date) ____/____/____
PN: ____ * PA: ____ **	Requested Procedure: _____ CPT code: _____
PROGRAM: _____ SURGEON: _____ Physician Group Tax ID# _____ Person completing this form: _____ Phone Number: (____) _____ Fax Number: (____) _____	

1. BMI Qualifications. *Please check current BMI Range and qualifications that apply.*

- a. **BMI: ≥40 documented in medical record**
- b. **BMI 35 to 39.9 with one or more of the following conditions that are not responding to optimal medical management:**
- Hypertension (consistent blood pressure of 140/90 or greater)
 - Dyslipidemia with cholesterol LDL greater than or equal to 130 mg/dl.
 - Diabetes with documented glycosylated hemoglobin levels greater than or equal to 7
 - Significant obstructive sleep apnea. (i.e. failure of CPAP use or other related sleep apnea treatments).

2. PRE-Operative Participation in A Call to Change Weight Loss Management program.

Please check and indicate date of referral and anticipated surgical date.

- A Completed Referral to HealthPartners pre-surgical phone course, "A Call to Change", has been made.**
- Date referral was made to "A Call to Change" phone course:** ____/____/____
- For providers with access security to HealthPartners website at: : www.hphealthbehaviorgroup.com/refsys*
 - For providers without security access, please call 1-800-720-1687.*
- Exempt from Referral –**
- Patient has qualifying BMI with urgent health care condition. State condition:**

- Anticipated Date of Surgery** ____/____/____

3. PRE-Operative Behavioral Health and Medical Surgical Clearance.

Please complete below with accompanying signatures.

Psychological evaluation and surgical clearance.

Psychological evaluation was done ____/____/____ by _____.

I certify that the patient has been seen and cleared for surgery: _____
 (Signature of Operating Surgeon)

Medical evaluation and surgical clearance.

Medical evaluation was done on ____/____/____ by _____.

I certify that the patient has been seen and cleared for surgery: _____
 (Signature of Operating Surgeon)

***PN: Prior Notification:** Benefit determination for Designated Providers only. No supporting documentation required.

****PA: Prior Authorization.** Health Plan coverage determination for Non-designated providers. Supporting documentation required.