



**Bariatric Bypass Surgery
Prior Authorization Form**

Please return completed form to the Utilization Management Department at (401)459-6023.

Please refer to Neighborhood's *Clinical Medical Policy* which is available on our Neighborhood web site, www.nhpri.org for more detailed information about this benefit, authorization requirements, and coverage criteria.

MEMBER INFORMATION

Member's Name:	Member's ID #:	Member's DOB:
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PROVIDER INFORMATION

Provider's Name:	Provider ID # (Please call Provider Services for your ID #):	Date of Request:
Date of Service:	Previous Auth #:	Place of Service (City/Town)/Facility:
Provider's Phone #:	Provider's Fax #:	Provider's Contact Name:

CLINICAL INFORMATION
Inpatient Services Outpatient Services

Diagnosis & Diagnosis Code:	Procedure & Procedure Code:	
Current BMI:	Height:	Weight:
Describe impact on Activities of Daily Living:	_____	
Describe co-morbid or other health conditions:	_____	
Describe medically supervised weight loss attempts in last 6 months:	_____	
Comment on demonstrated ability to comply with medical regimen:	_____	
List any current psychiatric/psychosocial co-morbidities & treatment in place:	_____	
Comment on ability to understand risk of gastric bypass surgery:	_____	

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Treating Physician:	Date:
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NEIGHBORHOOD DECISION

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	<input type="checkbox"/> Not Approved - Letter to Follow