Neighborhood Health Plan OF RHODE ISLAND™

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:
PROVIDER INFORMATION		
Provider's Name:	Supplier ID or NPI #:	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 ☐

CPT Code:	Units:	CPT Code:	Units:

Diagnosis:	Diagnosis 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:

NEIGHBORHOOD DECISION
Authorization is not a guarantee of payment.

Authorization #:	Dates of Service:	Services Approved:
UM Initials:	Notification Date:	☐ Not Approved - Letter to Follow