BARIATRIC SURGERY
PRIOR AUTHORIZATION REQUEST

Please Return <u>this cover sheet</u> and <u>all required information</u> to: **Attn: _____**

Fax: (406) 523-3111

Phone: (855) 999-1052

Mail: **Allegiance Benefit Plan Management, Inc.**
P.O. Box 3018
Missoula, MT 59806-3018

COMPLETED BY ORDERING PHYSICIAN: **Sent By: _____**

Patient Name:	Patient Health Plan ID #:	Patient Date of Birth:
Provider Name:	Provider TIN:	Provider Phone: Provider Fax:
Request Date:	Scheduled Date:	

Inpatient Outpatient

Please provide the following information:

1. Complete diagnosis, description of the procedure, and physician letter of medical necessity.
2. Medical Records to include the following:
    a. Recommendation from the attending Physician for bariatric surgery; and
    b. Medical records from the attending Physician for the twelve (12) month period prior to authorization for surgery, which must include documentation of active participation in a weight loss program for at least six (6) consecutive months within the twelve months prior to authorization for surgery and at least three (3) office visits specifically relating to weight loss during the six (6) month period; and
    c. A nutritional and mental evaluation and approval for bariatric surgery from the Bariatric Institute; and
    d. Bariatric surgeon's evaluation and recommendation for bariatric surgery; and
    e. Documented two (2) year history of morbid obesity and is at least 18 years of age.

Upon receipt of all required information, the Plan will provide a written response to the written request for preauthorization. Please allow three (3) business days for a response.

The benefits available are conditional on the participant's employment status, plan eligibility, payment of premium, amount of benefits remaining, plan provisions and plan exclusions. If information obtained at the time of claim places the service(s) in an excluded category or definition, the claim will not be payable. The benefits quoted are not guaranteed. Final determination of benefits to be paid will be made at the time a claim is submitted for payment, with review of the necessary medical records and other information. Predeterminations are valid for 60 days from the issue date.