Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Bariatric Surgery Assessment Form: Patient Referral Information

Demographic information

Primary care physician _____ Date of request _____
Address _____ Phone number _____
_____ NPI _____

Member name _____ BCN contract number _____
Address _____ Phone number _____
_____ Date of birth _____

Sex: ❑ Male ❑ Female • Height: _____ • Weight: _____ lbs. • BMI _____

Comorbidities (Check all that apply.)

❑ Atherosclerotic heart disease
❑ Congestive heart failure
❑ Coronary artery disease
❑ Degenerative joint disease
❑ Diabetes mellitus
❑ Hyperlipidemia
❑ Hypertension
❑ Sleep apnea
❑ Stroke

List other(s):
_____
_____
_____
_____
_____

Fax the following information to BCN at 1-800-675-7278:

1. Completed *Physician-Supervised Weight Loss Progam 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 presurgical assessment. Providers should call BCN Care Management at 1-800-392-2512 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 below by the physician.

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

Revised April 2012