REQUEST FOR CERTIFICATION

BlueCross BlueShield of Alabama

Bariatric Services Prior to Start of Care

* Please verify benefit information before submission of form *

PATIENT INFORMATION

Patient Name _____

DOB (must be 18 years of age) _____

Name of Contract Holder _____

Primary Contract Number _____

PROVIDER INFORMATION

Facility _____

Facility Address _____

Facility Phone and Fax numbers _____

Physician _____

Physician Address _____

Physician Phone and Fax numbers _____

SERVICES REQUESTED

Please attach clinical documentation with this cover sheet and include the following information:

Primary Diagnosis code _____

CPT code(s) _____

Will this be an Inpatient or Outpatient procedure? _____

Date of Surgery _____

History and Physical (performed by bariatric surgeon) _____

Smoking Status _____

Co-Morbidities _____

CURRENT AND PAST 3 YEARS WT/HT/BMI HISTORY	6 CONSECUTIVE MONTHS NUTRITION COUNSELING

Please fax requests for:

Inpatient to 866-713-6516 Outpatient to 205-220-9560