

HEALTHY WEIGHT CENTER
Phone: (231) 935-8533
Fax: (231) 935-8609**Comprehensive Weight Management Program
Prior Authorization and Referral Form****Fax form to both facilities:****1. Comprehensive Weight Management Program**

FAX: (231) 935-8609 PHONE: (231) 935-8533

2. Priority Health

FAX: (888) 647-6152 PHONE: 1-800-828-8302

Priority Member ID #: _____

Plan/Product Type: EPO HMO POS SF-POS PPO Medicaid MedicarePatient Name: _____ D.O.B.: ____/____/____
(Last) (First)Address: _____
(Street) (City) (Zip)

Phone: Home (____) _____ Other: (____) _____

 Initial Request Retreatment Request

Start Date of Last Program: _____

CLINICAL CONDITION

Date weight and height measured: _____

Current Weight: _____ Current Height: _____ BMI: _____

CHECK CRITERIA THAT APPLIES:

- BMI greater than or equal to 35 and two obesity-related co-morbidities *OR*
- BMI greater than or equal to 40 and one obesity-related co-morbidities *OR*
- BMI greater than or equal to 45 (co-morbidities not needed)

CO-MORBIDITIES: CHECK ALL THAT APPLY AND LIST MEDICATIONS FOR EACH AS APPLICABLE

- Diabetes (HbA1C greater than 8.0) HbA1C _____
- Hypertension requiring medication _____
- GERD (persistent symptoms despite daily medications) _____
- Symptomatic Sleep Apnea A/H Index = _____
- Significant cardiac disease (Documented ASHD, LVH or RVH)
Diagnosis: _____
- Hyperlipidemia (greater than 30mg/dl above goal) requiring medication (list all medications below)
HDL: _____ LDL: _____ TG: _____ Total: _____
1. _____ 2. _____ 3. _____
- Degenerative joint disease markedly limiting daily activities
- Non-alcoholic steatohepatitis (NASH)
- Depression requiring medication and psychological counseling
- No co-morbidities present

CONTRAINDICATIONS TO PHYSICAL ACTIVITY

- Unrestricted
- Progressive exercise (no restrictions)

Primary Care Physician: _____**PCP Phone: (231)** _____**Signature:** _____**PCP Fax: (231)** _____