LOUISIANA BLUE

Office of Group Benefits
Bariatric Surgery Benefit Enrollment Form

OGB Fax 225-342-9917
******Complete ALL sections of the form******

Evaluation Date: _____

Patient Information

Last Name: _____ First Name: _____ MI: _____ Member Number: _____

Patient's Phone #: _____ Patient's Email Address: _____

SSN: _____ Patient's DOB: _____ Patient's Age: _____ Patient's Sex: ☐ Male ☐ Female

Patient's Employer: _____ Employer's Phone #: _____

Requestor Information

Office Contact Name:_____ Office Contact Email Address: _____

Office Phone #: _____ Office Fax #: _____

Physician Name: _____ Provider National Provider Identifier (NPI) Number: _____

Place of Bariatric Surgery Service Requested

Facility Name: _____ Facility National Provider Identifier (NPI) Number: _____

Is this facility accredited by the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery's Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)? ☐ Yes ☐ No

Clinical Information

Primary Diagnosis: _____ **Primary Diagnosis Code**: _____

Co-Morbidity: _____Dx Code: _____ **Co-Morbidity**: _____ Dx Code: _____

Weight: _____ Height: _____ BMI: _____

CPT Code for Office Consult/Evaluation:_____

For OGB Office Use Only

This member has met the eligibility requirements set forth by the State of Louisiana Office of Group Benefits based on Act 388 of the 2021 Regular Legislative Session. ☐ Yes ☐ No

Signature: _____ **Date:** _____