



Louisiana



# 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: \_\_\_\_\_