



Wellmark Blue Cross Blue Shield of Iowa
Wellmark Health Plan of Iowa, Inc.

Independent Licensees of the Blue Cross and
Blue Shield Association

PHYSICIAN CERTIFICATION FOR MORBID OBESITY SURGERY

(This form must be completed by the primary care physician or treating physician)

In order to process your request for bariatric surgery, you must have your primary physician complete this certification and return or fax it to (515) 376-9016 with a completed prior approval form. We will be unable to complete your prior approval request without this documentation.

Patient Name: _____

Patient's Date of Birth: ____/____/____

BMI (Body mass index): _____

Current height in inches: _____

Most current weight in pounds: _____ Date: ____/____/____

Number of years patient has been considered morbidly obese: _____

1. Yes No This patient has failed to achieve and sustain weight loss with the following *supervised* programs:

Program	Dates of patient participation	From:	To:
<input type="checkbox"/> Weight Watchers:		____/____/____	____/____/____
<input type="checkbox"/> Jenny Craig		____/____/____	____/____/____
<input type="checkbox"/> Nutri System		____/____/____	____/____/____
<input type="checkbox"/> Physician supervised programs		____/____/____	____/____/____
<input type="checkbox"/> Registered Dietician programs		____/____/____	____/____/____
<input type="checkbox"/> Other (specify): _____		____/____/____	____/____/____

2. Co-morbid Conditions: Please check all severe co-morbidities your patient is experiencing, and any current treatments.

Morbidity	Treatment
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Cardiopulmonary Conditions	_____
<input type="checkbox"/> Diabetic Complications	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Sleep Apnea	_____
<input type="checkbox"/> Debilitating Arthritis or joint disease	_____
<input type="checkbox"/> Other: _____	_____

3. I have discussed postoperative life style changes with my patient including:

Life long dietary restrictions Yes No

Permanent life style changes Yes No

Relapse potential Yes No

Risks and benefits Yes No

Yes No - This patient has verbalized understanding of the impact of his/her life following surgery.

Yes No - The patient has assured me of his/her motivation to comply with permanent lifestyle changes.

Yes No - In my opinion, this patient is an acceptable operative risk.

Physician's Signature: _____ Date: ____/____/____