



**Medical Management
Referral for Exclusive Care Pathways to Health Program**

P.O. Box 1508, Riverside CA 92502-1508 - Office 877-755-0033 Fax 951-955-0035

Chart notes must be attached

Patient Name: _____ Date: _____

Member ID#: _____ DOB: _____ City _____ Phone #: _____

Referring Provider: name, address, phone & fax number		Exclusive Care Pathways to Health Bariatric Program	
Signature		Office Contact: name, number	
Diagnosis:	ICD-10 Code:	CPT Code:	

**Referral Criteria:
Patients with BMI 30 or greater
Patient Information**

Age: _____ Height: _____ Weight: _____ BMI: _____ **(Weight in pounds X 703)**
(lbs/inches²) (Height in inches²)

Does the Patient have:

- Diabetes Mellitus Insulin Treatment
- Complications: Retinopathy Nephropathy Neuropathy Peripheral arterial Insufficiency
- Hyperlipidemia
- Established Coronary Artery Disease
 - Bypass surgery CHF Angioplasty Angina Pectoris
- Obstructive Sleep Apnea requiring continuous nocturnal usage of CPAP
- Hypertension

Reviewer's Comments _____

Approved _____ **Denied** _____ **Pending** _____
Date Date Date

Authorized Signature	Control Number
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AUTHORIZATION IS VALID FOR 90 DAYS FROM APPROVAL DATE