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/inches^2) **(Height in inches^2)**

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

Authorized Signature	Control Number

AUTHORIZATION IS VALID FOR 90 DAYS FROM APPROVAL DATE