Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter or attach it to your **online request**.

This form should not be used if the beneficiary has had a previous bariatric surgical procedure. If questions one, two and three below are not met, the beneficiary does not meet the requirements for bariatric surgery and you may receive a denial letter.

Beneficiary height: _____

Beneficiary weight: _____

Beneficiary body mass index (BMI): _____

1. Does the beneficiary have a body mass index greater than or equal to 40 kg/m2? ☐ Yes ☐ No

   OR

   Does the beneficiary have a body mass index of 35–39.9 kg/m2 with one clinically significant co-morbidity?

   ☐ Yes ☐ No

   If yes, check the applicable boxes below:

☐ **Diabetes mellitus** based on medications (for example, insulin, metformin, glyburide or glypizide) and diagnosed by a primary care provider, internist or endocrinologist. If the diagnosis is only documented by the bariatric surgeon and the patient is not taking diabetic medication, query for the basis of the diagnosis. (Diabetes can be confirmed by a history of a fasting glucose greater than 126 mg/dl or a two-hour glucose tolerance test of 200 mg/dl or a HbA1c greater than seven [7]). Abnormal glucose metabolism or borderline diabetes should not be accepted as diabetes.

☐ **Hypertension** with blood pressure (BP) documented as greater than 140/90 or documented use of BP medications with a diagnosis of hypertension (HTN). A diagnosis of HTN, with BP less than or equal to 140/80 and taking no blood pressure medications should not be accepted as a current diagnosis of HTN. If HTN is listed as a diagnosis and there are no blood pressure measurements and no blood pressure medications query for the basis of the diagnosis and for current blood pressure measurements.

☐ **Cholecystitis or symptomatic cholelithiasis**. Physician diagnosis supported by abdominal ultrasound, hepatobiliary iminodiacetic acid (HIDA) scan or endoscopic retrograde cholangiopancreatography (ERCP).

☐ **Pickwickian syndrome/OSAS** with abnormal sleep study, documentation of continuous positive airway pressure (CPAP) use for obstructive sleep apnea (OSA) and diagnosis by a pulmonologist or sleep specialist (snoring or fatigue alone does not count).

☐ **Other severe respiratory disorder** such as asthma with the use of asthma medication, emergency department visits for asthma or admissions for asthma.

☐ **Hypothalamic disorder**

☐ **Severe arthritis of weight bearing joints** with radiographic evidence of osteoarthritis of weight bearing joints. (Joint pain alone does not count.)

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☐ **Coronary artery disease**
A history of myocardial infarction (MI), angina, cardiac bypass/stent, congestive heart failure, abnormal cardiac catheterization or other:

_____

☐ **Pulmonary hypertension**
☐ **Obesity-related cardiomyopathy**
☐ **Pseudotumor cerebri**
☐ **Non-alcoholic fatty liver disease (NAFLD)**

2. Has the beneficiary completed growth (18 years of age or documentation of completion of bone growth)?
☐ Yes ☐ No

3. Has the beneficiary been previously unsuccessful at nonsurgical medical treatment for obesity as documented in the beneficiary's record with at least monthly clinical encounters with the physician? Physician supervised programs consisting exclusively of pharmacological management are not sufficient to meet this requirement.
☐ Yes ☐ No

If patient has TRICARE Select coverage STOP here. Physician please sign and date at bottom of this document.
No further information is required for TRICARE Select patients.

4. Has the patient had an adequate pre-op evaluation? Check the services that have been completed.
☐ Cardiac/pulmonary evaluation ☐ Dietary consult ☐ Psych consult

5. Does patient have evidence of peptic ulcer disease or gastritis? ☐ Yes ☐ No
If yes, has peptic ulcer disease been ruled out or treated? Check the applicable box below:
☐ Negative H. pylori (If the H. pylori test is positive but treatment is documented, consider the H. pylori negative.)
☐ Esophagogastroduodenoscopy (EGD)
☐ Upper gastrointestinal (UGI)

6. Is there a history of drug or alcohol abuse? ☐ Yes ☐ No
If yes, has the patient been alcohol or drug free for greater than one year? ☐ Yes ☐ No

7. Has the patient been smoke-free greater than six weeks or has no history of smoking? ☐ Yes ☐ No

8. Is there a mental health disorder (for example, severe psychosis, personality disorder or anxiety disorder)?
☐ Yes ☐ No
If yes, answer both questions below:
a. Is the condition being treated? ☐ Yes ☐ No
b. Does the mental health consultant agree with the recommended surgery? ☐ Yes ☐ No

9. Does the patient understand the surgical risk, post-procedure complications and follow-up? ☐ Yes ☐ No

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's Printed Name and Title: _____

TIN: _____

Signature: _____ Date: _____