

SHBP 2016 Bariatric Surgery Pilot Program Member Application

To be eligible to apply for the 2016 benefit year, you must meet and agree to all the requirements outlined in Sections A & B. **This application must be submitted to your 2016 medical claims administrator no earlier than January 1, 2016 & postmarked no later than February 4, 2016.**

Section A

The name and following information of the applicant (please print clearly):

- Employee name and SSN _____
- Applicant name _____
- Applicant SHBP member ID card number (if known) _____
- 2016 Medical Claim Administrator: **BCBSGa** _____ **UHC** _____ **Kaiser Permanente** _____
- Applicant date of birth _____
- Applicant mailing address _____
- Applicant primary phone number _____
- Applicant secondary phone number _____
- Best day(s) and time(s) to be reached _____ am _____ pm _____
- Applicant email address _____

You must agree to all of the following SHBP eligibility and participation requirements and initial in the box following each requirement to confirm your understanding of the requirements: Initial Here

1. I have completed and submitted my SHBP 2016 Bariatric Surgery Pilot Program member application.	
2. SHBP is my primary insurance.	
3. I do not use tobacco.	
4. I have been covered under SHBP as my primary insurance for at least two years prior to submitting this application.	
5. I have completed the required on-line 2016 health assessment.	
6. I have not had previous bariatric surgery.	
7. I consent to provide personal and medical information as requested by the SHBP or the medical claim administrator.	
8. If I am selected to participate in the SHBP 2016 Bariatric Surgery Pilot Program, I agree to enroll in a SHBP case management program. ✓ I will also participate in a pre-operative and 24-month post-operative SHBP case management program. ✓ This program requires regular calls with a nurse case manager.	
9. If I am selected to participate in the SHBP 2016 Bariatric Surgery Pilot Program, bariatric surgery and related services will be considered a covered benefit. Applicable co-pays, deductibles, and/or co-insurance apply to all covered services. Any travel or lodging costs associated with the bariatric surgery, including attempts to qualify, are not covered. I understand I will be responsible for the 2016 Plan year co-pays/co-insurance and deductibles for these services up to the maximum allowed amount for covered services.	
10. If I am selected to participate in the SHBP 2016 Bariatric Surgery Pilot Program, I understand my bariatric surgeon may require me to pay additional fees, not covered by the plan, to cover items such as vitamins, protein shakes and other supplements. I also understand my surgeon may charge additional pre-operative fees that may not be covered under my health plan.	
11. I intend to continue coverage under SHBP for two years following the approved surgical procedure date.	
12. I will comply with any and all requests by the SHBP for postsurgical medical and productivity information, and such agreement shall survive my Plan participation in the SHBP. Failure to comply with these requirements may result in disenrollment from the SHBP 2016 Bariatric Surgery Pilot Program and the member may be responsible for all claims associated with the program.	

By signing, you certify that you meet and agree to all of the SHBP 2016 Bariatric Surgery Pilot Program eligibility requirements, and if randomly selected, you will receive a required multi-disciplinary health evaluation with a metabolic and bariatric surgeon. If surgical authorization is given by your medical claims administrator, you agree to comply with all the above eligibility and participation requirements.

Applicant signature _____ **Date** _____

Employee name and SSN _____

Applicant name _____

Applicant SHBP member ID card number (if known) _____

Medical Claim Administrator for 2016: BCBSGa____ **UHC**____ **Kaiser Permanente**_____

Applicant date of birth_____

Section B

This section may be completed by your personal physician prior to January 1, 2016.

Applicant referring physician and contact information (please print clearly):

- Physician name _____
- Physician address _____
- Physician telephone _____

Physician certification for the applicant named in Section A:

1. My patient has a body mass index (BMI) greater than 40, **or**
2. My patient has a BMI greater than 35 with one or more co-morbidities (such as diabetes, hypertension, gastro-esophageal reflux disease, sleep apnea, or asthma) **and**
3. BMI: _____ Co-morbid Conditions: _____
4. My patient does not use tobacco.

By signing, I certify that my patient meets the above clinical criteria in Section B:

Physician signature _____ **Date** _____

Important Note: We anticipate a large number of applications for benefit year 2016. Please understand by submitting the SHBP 2016 Bariatric Surgery Pilot Program member application within the timeframe does not guarantee that you will be one of the 75 pilot participants randomly selected for benefit year 2016. After selection, eligibility and prior authorization criteria must also be met. Surgical authorizations for pilot program year 2016 are valid for surgery performed by December 31, 2016. Regardless of extenuating circumstances, no exceptions will be made for extending approvals beyond the 2016 benefit Plan Year. Any applications mailed to the Georgia Department of Community of Health or State Health Benefit Plan will not be considered for the SHBP 2016 Bariatric Surgery Pilot Program.