Washington Molina Medicaid
Bariatric Surgery Criteria
Pre-Surgical Assessment

(Requirements to Proceed to Stage II)

Fax this completed form and required documentation to (800) 767-7188 or
Mail to Molina Healthcare, P.O. Box 4004, Bothell WA 98041-4004

SECTION 1: GENERAL INFORMATION

PROVIDER INFORMATION		
Name of PCP who will supervise weight loss if member is approved for Stage II		
Provider NPI	Phone	Fax

MEMBER INFORMATION			
Member Name			DOB
Member Phone			Molina Member ID
Current Weight (Within Last Month)		Height	BMI
Pounds:	Date Weighed:		

SECTION 2: QUALIFYING QUESTIONS Please answer all questions.

Is the member between 18 - 59 years old? ☐ Yes ☐ No
Is the member's BMI 35 or greater? ☐ Yes ☐ No
Is the member pregnant? ☐ Yes ☐ No

1. Does the member have diabetes?

☐ **Yes**

a. Date of diabetes diagnosis:

b. Which test documents the client has diabetes?

☐ Hemoglobin A1c 6.5 or greater (Provide a copy of a diagnostic lab value. If newly diagnosed, send two qualifying A1c tests three months apart or one A1c and one of the following tests.)

☐ Random glucose > 200mg/Dl (Provide a copy of the diagnostic lab value.)

☐ 2-hour oral glucose tolerance test (Provide a copy of the diagnostic lab value and reference range.)

c. What diabetes medications does the member use at this time?

☐ **No**

2. Does the member have degenerative joint disease (DJD) of a major weight-bearing joint and is the member currently a candidate for replacement if weight loss is achieved?

☐ **Yes**

a. Provide the following documentation:
Diagnostic Imaging Report documenting severe DJD and an orthopedic consult recommending joint replacement as soon as weight loss is achieved.

☐ **No**

3. Does the member have a rare comorbid condition for which there is medical evidence bariatric surgery is medically necessary and the benefits of bariatric surgery outweigh the risk of surgical mortality?

☐ **Yes**

a. What is the rare comorbid medical condition?

b. Provide documentation that member has the medical condition and how bariatric surgery is the medically necessary treatment.

☐ **No**

4. Does the member have multiple sclerosis (MS) or any other medical condition that would increase the member's risk of surgical mortality or morbidity from bariatric surgery?

☐ **Yes**

☐ **No**

SECTION 3: ADDITIONAL INFORMATION

List all comorbidities related to obesity.

Does the member have mental health or substance abuse issues that may interfere with successful participation in a weight loss program? ☐ **Yes** ☐ **No**

Please attach required documentation in the following order:

1. Diabetes-related lab (if diabetic)
2. Diagnostic imaging reports and orthopedic consult (if PT requires joint replacement)
3. Detailed history and physical (required for each member requesting bariatric surgery)
4. Other lab work
5. Other supporting and relevant documentation you would like us to review

If the member is approved for Stage II of the Bariatric Surgery Program, I agree to partner with the member to meet the requirements of the program and understand that they have 180 days from the date of approval to meet the 5% weight loss requirement: ☐ **Yes** ☐ **No**

Provider Signature ______________________________