REQUEST FOR AUTHORIZATION OF REFERRAL TO NUTRITION/DIETARY SERVICES for OVERWEIGHT/OBESITY

Please complete this form and the CPMG request for authorization form, attach supporting clinical documentation, and FAX to CPMG CUSTOMER SERVICE at (858) 309-7977.
CPMG cannot review your request without this information.

Name of Referring Provider: ____________________________ Phone #: ______________________

Member Name: ____

Member ID# ____ DOB: _________________________

Referrals to Nutrition for dietary services for weight management will not be considered unless the following* are completed.
***Based on AAP 2007 Expert Committee recommendations.**

Assess for obesity	YES	NO
Calculation of BMI		
Plotting of BMI % on growth chart		

Clinical Evaluation	YES	NO
Blood pressure measurement		
Family history specifically asking about obesity, Type 2 DM, cardiovascular disease (CVD) and early CVD mortality		

Order appropriate lab tests	YES	NO
Fasting lipid profile		
ALT, AST		
Fasting glucose		
Thyroid function		

Health behaviors and attitudes	YES	NO
Assessment of diet		
Assessment of physical activity		
Determination of patient's readiness for change		

Nutritional services are considered medically necessary when one or more of the following weight-related conditions are present.
(*Please check all that apply):*

- ☐ Hyperlipidemia
- ☐ Diabetes/Glucose intolerance [Fasting glucose > or = 100 mg/dL]
- ☐ Non-alcoholic steatohepatitis
- ☐ Hypertension
- ☐ Acanthosis nigricans/Insulin resistance

**** ***Please include supporting clinical documentation, including growth curves and lab results, with the submitted referral*** ****