700 Ackerman Place, Suite 440
Columbus, OH 43202
(614) 292-4700 or (800) 678-6269
Fax (614) 292-2667

WEIGHT LOSS PROGRAM
PRIOR AUTHORIZATION REQUEST

Please be advised that all HOSPITAL BASED WEIGHT LOSS PROGRAMS covered by The Ohio State University Health Plan Inc. must be prior authorized. Any inquiries regarding this may be directed to a nurse case manager at the appropriate number listed above. The following information needs to be collected and faxed to OSU Health Plan prior to starting the program. If unable to fax, the information may be mailed.

Client Name	Member ID #	Client Relationship to Member: Self______ Wife_______ Husband_______ Son_______ Daughter_______
Date of Birth:	Gender: Male ☐ Female ☐	Client Address:
Program Name:		Program Tax ID:
Program's Address, Phone, & Fax Number:		
Date of First Service		Program Length in weeks
Hospital Name (if different from Program) ______________________________ Primary Care Physician Name		
Client's Height _________________ Weight __________ BMI __________		

Co-morbid conditions:
____
____
____

Total Program charges ________________________

Contact Person Phone

OSU Health Plan will complete this form and send a copy to both the program and to the client.

Prior Authorization Number*: __________________ Weekly Rate (50% reimbursable) __________________

Date Span of Authorization: __________________________________

OSU Health Plan Case Manager ___________________________________ Date __________________

*Note to member: Please retain the authorization number listed above in your records. This is necessary for you to include when you submit any reimbursement requests for Weight Loss Program coverage to NGS.