Aplos Health Plans Preauthorization Request Form

Submit completed forms and clinical information outlined below by fax to **515-328-6597, or** by secure email to **Aplos@innovativecare.com**.

"A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could **seriously jeopardize the life or health of the claimant** or the **ability of the claimant to regain maximum function;** or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to **severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim**."

❑ I certify that this request meets the above definition for Urgent processing according to the Department of Labor.

Patient Information		
Last Name	First Name	Date of Birth
Employer/Plan Name		Plan ID
Address, City, State, Zip		Phone
Subscriber Name (if different than patient)		Subscriber Relationship

Your Contact Information (Submitted by)		
Name	Phone	Fax
Email		

Provider Information	
Provider Name	Specialty
Phone	Fax
Provider Primary Address (include suite # if applicable)	NPI
	TIN
Facility Information	
Facility	
Phone	Fax
Facility Address (include suite # if applicable)	NPI
	TIN

See next page for service details

Bariatric Surgery Service Request		
Date of Service		❑ Not Scheduled
Type of Service	❑ Inpatient	❑ Outpatient
Description of Service(s) Requested:		
CPT Code(s)	ICD Code(s)	
Additional Information		
Will the requested procedure be performed at a Center of Excellence?	❑ Yes	❑ No
Please indicate the services that the program provides:		
❑ Mental Health Consultation	❑ Nutritional Counseling	❑ Exercise Counseling ❑ Patient Support Program(s)

Clinical Information: For General Preauthorization requests, please include the following information as appropriate:

- ☐ Most recent **History & Physical**
- ☐ **Bariatric history** including any previous bariatric surgeries and BMI for last 2 years
- ☐ **Co-morbid conditions** (e.g. Diabetes, GERD, etc.)
- ☐ **Diagnostic testing** results (e.g. EGD, MRI, HIDA, etc.)
- ☐ **Endocrine testing**. **Required: TSH level** (Thyroid Stimulating Hormone)
- ☐ **Psychiatric Evaluation**
- ☐ If diagnosis of Obstructive Sleep Apnea (OSA), send the **Polysomnogram** (PSG) report
- ☐ **Compliance documentation** to a multidisciplinary non-surgical program including low calorie diets, exercise, and behavior modification of at least 3-6 months
- ☐ Any other **pertinent clinical information** that substantiates medical necessity for the requested service(s)

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