carrumhealth

Walmart/Sam's Club
Program Verification Form (PVF) for Weight Loss Surgery Benefit

Your patient wishes to participate in a Carrum Health - administered Weight Loss Surgery Benefit, which is designed for individuals seeking to improve their health.

The benefit is available for patients who meet the criteria for participation listed below.

1. **Primary Care Provider visit in the last 30 days**

AND one of the following:

Adult (age 18+)	**Adolescent (Age 14-<18)**
☐ Has a body mass index (BMI) ≥ 40 kg/m2 **OR**	☐ BMI ≥120% to <140% of the 95th percentile; or BMI ≥35 to <40 kg/m2 **OR**
☐ Has a body mass index (BMI) of 35 or higher and at least one or more obesity-related co-morbidities such as but not limited to type 2 diabetes, hypertension, sleep apnea, and other respiratory disorders, non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, gastrointestinal disorders, or heart disease	☐ BMI ≥140% of the 95th percentile; or BMI ≥40 kg/m2

Patients under the age of 18 will be evaluated by a nationally accredited adolescent bariatric surgery facility to determine if they are a candidate for bariatric surgery under this benefit. If approved, you may be asked to help facilitate services, including lab and medical clearance locally.

Patients 18 and over will be evaluated by a nationally accredited bariatric surgery facility to determine if they are a candidate for bariatric surgery under this benefit. If approved for surgery, you may be asked to help facilitate services, including lab and medical clearance locally.

Please note: This form is to validate clinical criteria for benefit eligibility.
It is not a precertification form for surgery.

IMPORTANT: Please return this form to the Program Administrator via secure fax at 773-249-0433 or email to walmartcareteam@carrumhealth.com.

Or mail to:
Carrum Health

640 N Lasalle, Suite 675

Chicago, IL, 60654

Once the patient is enrolled in the program, they will be referred to a COE facility. This is the facility that will review the patient's records and determine what surgery is best for them. Participants may not be able to request specific facilities or types of surgery after referral.

For questions regarding this form, please call Carrum Health at 888-890-7359.

All pages need to be completed and returned together to Carrum Health.

To be completed by patient

Patient Information				
First Name	Last Name	Date of Birth (MM/DD/YYYY)	Last four digits of Social Security Number	
Gender: ☐ Male ☐ Female ☐ Prefer not to identify				
Address: Street		City	State	Zip Code
Email Address (required)		Cell Phone	Home Phone	
Benefit ID Number (BID)		Patient Relationship to Employee		
Does patient have secondary healthcare insurance? ☐ Yes ☐ No		Does patient have Medicare Part A and B? ☐ Yes ☐ No If yes, please complete		
		Medicare ID #: Effective Date (MM/DD/YYYY):		

To be completed if patient is not the associate

Employee Information				
First Name	Last Name	Date of Birth	Last four digits of Social Security Number	
Address: Street		City	State Choose an item.	Zip Code
Email Address		Cell Phone	Home Phone	

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Patient Name: Click or tap here to enter text.

To be completed by medical provider

Please complete this form to confirm the patient meets the clinical criteria for consideration. Incomplete forms will be returned for additional information.

As the patient's provider, I attest that this patient meets the criteria for participation in the weight loss surgery program by checking below:

☐ Patient has completed a visit with their primary care provider visit in the last 30 days

AND one of the following:

Adult (age 18+)	**Adolescent (Age 14-<18)**
☐ Has a body mass index (BMI) ≥ 40 kg/m2 **OR**	☐ BMI ≥120% to <140% of the 95th percentile; or BMI ≥35 to <40 kg/m2 **OR**
☐ Has a body mass index (BMI) of 35 or higher and at least one or more obesity-related co-morbidities such as but not limited to type 2 diabetes, hypertension, sleep apnea, and other respiratory disorders, non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, gastrointestinal disorders, or heart disease	☐ BMI ≥140% of the 95th percentile; or BMI ≥40 kg/m2

Provider Verified Height and Weight		
Patient Height Feet:	Patient Height Inches:	Patient Weight Pounds:

Provider Verified Nicotine Use	
Has the patient used anything with Nicotine within the last 12 months?	☐ Yes ☐ No

Previous Surgery			
Does the patient have history of previous weight loss surgery?	☐ Yes ☐ No		
If yes, date of surgery (MM/DD/YYY):			
If yes, type of surgery (MM/DD/YYYY):			
Surgeon Name:			
Address: Street	City	State Choose an item.	Zip Code

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Does the patient have any of the following comorbidities?			
Type 2 Diabetes	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Dyslipidemia	☐ Yes	☐ No	
GERD	☐ Yes	☐ No	
Obstructive Sleep apnea	☐ Yes	☐ No	
Osteoarthritis	☐ Yes	☐ No	
Non-alcoholic Fatty Liver Disease	☐ Yes	☐ No	
Lipid Abnormalities	☐ Yes	☐ No	
Respiratory Disorders	☐ Yes	☐ No	
Gastrointestinal Disorders	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
Other	☐ Yes	☐ No	Please specify:

List all medications the patient is currently taking or attach patient medication list (REQUIRED):
Type of Medication

Physician Information			
Provider Name/Credentials	Facility/Clinic Name		
Address: Street	City	State Choose an item.	Zip Code
Email Address	Phone	Fax	

Provider Name/Credentials:_

Provider Signature: _____ Date: _____

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