contigohealth Walmart

Provider Verification Form
Walmart/Sam's Club Weight Loss Surgery Benefit

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 877.891.2693
Or mail to:
Contigo Health, LLC, PO Box 2584, Hudson, Ohio 44236-2584
Attn: WLS Program

For questions regarding this form, please call Contigo Health, LLC at 877.891.2689

Your patient, ____________________________, wishes to participate in the Walmart/Sam's Club Weight Loss Surgery
(Patient name)
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. Patients must meet the first requirement along with either the second or third requirement.

1. **Primary Care Provider visit in the last 30 days**
   AND
2. **Body Mass Index (BMI) of 40 or higher OR**
3. **Body Mass Index (BMI) of 35 or higher and at least one or more obesity-related co-morbidities such as type 2 diabetes, hypertension, sleep apnea, and other respiratory disorders, non-alcoholic fatty liver disease, osteoarthritis, lipid abnormalities, gastrointestinal disorders, or heart disease**

The patient 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.

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

All pages need to be completed and returned together to Contigo Health

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Patient Name: ______________________________

Employee Information ***(To be completed if patient is not the employee)*** PLEASE PRINT			
First Name	Last Name	Date of Birth	Last four digits of Social Security Number
		/ /	
Address: Street		City, State Zip Code	
Email Address		Cell Phone	Home Phone
		( ) -	( ) -

To be completed by medical provider

Please complete this form to confirm the patient meets the clinical criteria for consideration.

Patient Information ***(To be completed by medical provider)*** *PLEASE PRINT*		
Patient Height*:	Patient Weight*:	Patient BMI :
Is the patient a Nicotine User*?	☐ Yes ☐ No	
If patient is a Nicotine User, Type of Nicotine	☐ Cigarettes/Cigars ☐ Smokeless Tobacco ☐ E-Cigarettes ☐ Gum ☐ Patch	

Does the patient have any of the following? ***(To be completed by medical provider)***	
Type 2 Diabetes	☐ Yes ☐ No * If yes, date of diagnosis:
Hypertension	☐ Yes ☐ No * If yes, date of diagnosis:
Osteoarthritis	☐ Yes ☐ No * If yes, date of diagnosis:
Sleep apnea?	☐ Yes ☐ No * If yes, date of diagnosis: If yes, list current treatment to manage condition:
Non-alcoholic Fatty Liver Disease	☐ Yes ☐ No * If yes, date of diagnosis:
Lipid Abnormalities	☐ Yes ☐ No * If yes, date of diagnosis: If yes, list the most recent values: Total Cholesterol: LDL: HDL: Triglycerides: Date:

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Patient Name: ______________________________

Does the patient have a diagnosis of a comorbid condition? Please specify the condition *(To be completed by medical provider)*	
Respiratory Disorders	☐ Yes ☐ No * If yes, date of diagnosis: If yes, Is the patient on oxygen? ☐ Yes ☐ No If yes, please specify:
Gastrointestinal Disorders	☐ Yes ☐ No * If yes, date of diagnosis: If yes, please specify:
Heart Disease	☐ Yes ☐ No * If yes, date of diagnosis: If yes, please specify:
Other	☐ Yes ☐ No * If yes, date of diagnosis:
	If yes, please explain:*

**Required fields are indicated with an asterisk. Forms submitted without completion of the required fields will be returned for additional information.*

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Patient Name: ______________________________

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

Physician Information *PLEASE PRINT*		
Provider Name/Credentials	Facility/Clinic Name	
Address: Street	City, State Zip Code	
Email Address	Phone	Fax
	( ) -	( ) -

Provider Name/Credentials: ____
(*Please print*)

Provider Signature: ____________________________________Date: _________________________

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Information provided on this form will be used solely for the Weight Loss Surgery Benefit

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Walmart

Valued Plan Participant

The Associates' Health and Welfare Plan (AHWP) respects the dignity of each individual who participates in the Plan.

The AHWP does not discriminate on the basis of race, color, national origin, sex, age, or disability and strictly prohibits retaliation against any person making a complaint of discrimination. Additionally, we gladly provide our participants with language assistance, auxiliary aids and services at no cost. We value you as our participant and your satisfaction is important to us.

If you need such assistance or have concerns with your Plan services, please call the number on the back of your plan ID card. If you have any questions or concerns, please use one of the methods below so that we can better serve you.

For assistance, call the number on the back of your plan ID card.

To learn about or use our grievance process, contact the Associate Support Team at:

- 1-800-421-1362

To file a complaint of discrimination, contact the U.S. Department of Health and Human Services, Office of Civil Rights:

- Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)
- Website: https://ocrportal.hhs.gov/ocr/cp/wizard_cp.jsf
- Email: OCRCompliant@hhs.gov

Interpreter Services are available at no cost. 1-800-421-1362

Arabic

عربي

خدمات الترجمة الفورية متاحة دون تكلفة. 1-800-421-1362.

Burmese

မြန်မာ

စကားပြန်ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ 1-800-421-1362

Chinese

汉语普通话

翻译服务免费提供。1-800-421-1362.

Farsi

فارسی

خدمات مترجم بدون هیچ هزینه ای در دسترس می باشد. 1-800-421-1362

French

Français

Des services d'interprètes sont disponibles sans frais. 1-800-421-1362.

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Haitian Creole

kreyòl ayisye

Gen Sèvis entèprèt ki disponib gratis. 1-800-421-1362.

Japanese

日本人

通訳サービスは無料でご利用いただけます。1-800-421-1362.

Korean

한국어

통역 서비스를 무료로 이용하실 수 있습니다. 1-800-421-1362.

Polish

Polski

Usługi tłumacza dostępne są bez żadnych kosztów. 1-800-421-1362.

Portuguese

Português

Serviços de interprete estão disponíveis grátis. 1-800-421-1362.

Punjabi

ਪੰਜਾਬੀ

ਦੋਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। 1-800-421-1362.

Romanian

Română

Serviciile de interpretariat sunt disponibile gratuit. 1-800-421-1362.

Russian

Русский

Переводческие Услуги оказываются бесплатно. 1-800-421-1362.

Somali

Af-Soomaali

Adeegyada Turjumaanka waxaa lagu heli karaa kharash la'aan. 1-800-421-1362.

Spanish

Español

Los servicios de interpretación están disponibles de manera gratuita. 1-800-421-1362.

Swahili

Kiswahili

Huduma za tafsiri zipo bila malipo. 1-800-421-1362.

Vietnamese

Tiếng Việt

Dịch Vụ Thông Dịch có sẵn miễn phí. 1-800-421-1362.