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:
Health Design Plus, 1755 Georgetown Road, Hudson, Ohio 44236
Attn: WLS Program

Your patient, _____, wishes to participate in the Walmart/Sam's Club Weight Loss Surgery benefit which is designed for individuals seeking to improve their health.
(Patient name)

The benefit is available for patients (employees, spouses and adult dependent children age 18+) who have been on an eligible medical plan for at least 12 months, and who meet the clinical criteria for participation listed below. Patients must meet the first requirement along with either the second or third criteria.

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
		/ /	
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 Health Design Plus

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 *
Osteoarthritis	☐ Yes ☐ No *
Sleep apnea?	☐ Yes ☐ No * If yes, list current treatment to manage condition:
Non-alcoholic Fatty Liver Disease	☐ Yes ☐ No *
Lipid Abnormalities	☐ Yes ☐ No * If yes, list the most recent values: Total Cholesterol: LDL: HDL: Triglycerides: Date:

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, Is the patient on oxygen? ☐ Yes ☐ No If yes, please specify:
Gastrointestinal Disorders	☐ Yes ☐ No * If yes, please specify:
Heart Disease	☐ Yes ☐ No * If yes, please specify:
Other	☐ Yes ☐ No *
	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.

List all medications the patient is currently taking or attach patient medication list: ***(To be completed by medical provider)***
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

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 People Services 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.

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.