



# AUTHORIZATION REQUEST FORM (ARF)

## For CalOptima Kids Weight Management Program Services

### PATIENT/PROVIDER INFORMATION

Patient Name: \_\_\_\_\_  M  F D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_  
Last First  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Client Index # (CIN): \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Referring Provider:	Health Network:
Provider Address:	Provider Phone:
City: State: Zip Code:	Provider Fax:
Office Contact Name/Phone #:	Physician's Signature:
Diagnosis: (1) _____ (2) _____	ICD.9 (1) _____ ICD.9 (2) _____

### AUTHORIZATION REQUEST

**CRITERIA:**

- Enrollment in the CalOptima Kids - Healthy Families Program (ELIGIBILITY must be verified at the time services are rendered).
- Meets  $\geq 95$  Percentile Body Mass Index (BMI) BMI = (Weight in lbs/Height in inches)/Height in inches x 703  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Body Mass Index Score: \_\_\_\_\_
- Child is 4 - 18 years old
- No Co-morbidities (Some exceptions will be made for children with uncomplicated co-morbidities. These will be evaluated on a case by case basis. Please list possible uncomplicated co-morbidities below).
- Lab results attached (The following labs must be included in order to process ARF: CBC, Cholesterol Panel HDL, LDL, T3,T4, TSH, Liver Function Tests, C-Peptide and Urinalysis)

**HISTORY AND RELEVANT LAB VALUES:**

\_\_\_\_\_  
 \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**FOR CalOptima Kids USE ONLY**

<b>STATUS</b>	Authorization Number #
<input type="checkbox"/> Approved	Signature: _____ Date: _____
<input type="checkbox"/> Community Based Health Education Program	
<input type="checkbox"/> Medical Based Intervention Program	Comments:
<input type="checkbox"/> Not Approved	Phone Number: