

CHNCT BARIATRIC SURGERY REQUEST FORM

Member's Name: _____ Date of Birth: _____

Member's ID#: Plan: Husky _____ Charter Oak _____

Date of Surgery: _____ Hospital: _____

Surgeon: _____ Name of Contact: _____

Phone: _____ Fax: _____

Inpt: _____ #days: _____ Proc Code: _____ Diag Codes: _____

Height: _____ Weight: _____ BMI: _____

Clinical notes must be faxed to CHNCT for review
Please fax request to 203-265-3994. Thank You

Please Include the Following Information:

- Cardiac evaluations: EKG and Stress Test
- Pulmonary: PFT/Sleep Study
- Psych evaluation
- Nutrition: 6 months of supervised nutritional notes with weight

****PLEASE ALLOW 2 BUSINESS DAYS FROM RECEIPT OF
ALL CLINICAL INFORMATION TO PROCESS REQUEST****