

Physician requesting referral: _____

Patient Name: _____ Phone: _____

DOB: _____ Address: _____

Insurance: _____

For Weight Management Referral ONLY:

If patient is a UPHP client, please request authorization for services prior to submitting this referral.

UPPER PENINSULA HEALTH PLAN REQUIRES PRIOR AUTHORIZATION

Authorization Number: _____

Circle primary diagnosis code, state the reason for this referral and fax to number below:

DIABETES EDUCATION

Sarah Balko, RD, CDE

Phone: 225-3473

Fax: 225-7593

Type 1, controlled	250.01
Type 1, uncontrolled	250.03
Type 2, controlled	250.00
Type 2, uncontrolled*	250.02
Abnormal glucose tolerance	
during pregnancy	648.84
Abnormal Glucose	790.29

***LABWORK REQUIRED
for new diagnosis of diabetes**

- Fasting blood glucose ≥ 126 on 2 separate occasions
 or
- 2 hour GTT ≥ 200 on 2 separate occasions
 or
- Random blood glucose ≥ 200 with symptoms of uncontrolled diabetes

MEDICAL WEIGHT MANAGEMENT

Erica Griffin, MD

Donna Marlor, RD, BSN, MA

Monica Nelson, RD, Pediatric Specialist

Phone: 225-6955

Fax: 225-7997

Overweight*	278.02
Severe Obesity	278.01
Morbid Obesity	278.01
S/P Bariatric Surgery	V45.86
S/P Gastrostomy Tube	V44.1
S/P Lab band	V45.86
Vitamin Deficiency, S/P Bariatric Procedure	269.2X
Protein Deficiency, S/P Bariatric Procedure	260

Referral to see: Physician Dietitian

* Healthy Weight classes are reimbursed by flex medical accounts if reason for referral and physician signature lines are completed.

Reason for Referral/Other: _____

****Please use surgical weight loss referral form for patients desiring surgical weight management****

Physician Signature: _____ Date: _____

Required for Medical Weight Management Only:

Physician NPI: _____ Physician Michigan License#: _____