UNIVERSITY OF ARKANSAS SYSTEM

Physician Attestation Form

UAS Weight Loss Program

Program Guidelines

Level I: All UAS Health Plan members are eligible to receive annual nutritional counseling (one visit per plan year) with a registered dietitian at an in-network facility.

Level II: Members who have a BMI of 27 or greater are eligible to enroll in a nutritional counseling weight loss program. This program allows up to three additional annual visits (four total) with a registered dietitian at an in-network facility. The member must be under the direction of a physician with documentation through a Physician Attestation Form.

Level III: Members who have a BMI of 30 or greater are eligible for reimbursement of the cost of non-surgical weight loss programs up to $1,000 lifetime maximum. The member must be under the direction of a physician with documentation through a Physician Attestation Form. Coverage will be for instruction, education, weight monitoring, counseling and support. Initial and routine lab work is covered as provided within the benefit. Weight loss products and meal replacement shakes are not covered.

Section I. Member Information				
Full Name *(Last, First, MI)*	**Date of Birth**	**Member ID No.**	**Contact Phone No.**	
Street Address		**City**	**State**	**ZIP**

CAMPUS of Employee *(Please Check One)*

☐ ASMSA ☐ CES ☐ UAF ☐ UACCB ☐ UALR

☐ UAM ☐ UAMS ☐ UAPB ☐ WRI ☐ PCCUA ☐ Other: _____

Section II. Weight Loss Program Information	
Name of Weight Loss Program	
Location (Street Address/City/State)	
Program Start Date	
Physician Name	

Section III. Physician Attestation

I attest to the following:

This member has a BMI of _____.

If individual has a BMI of 30 or greater:

1. This member is a part of a physician-directed weight loss program and is under my supervision during the weight loss process.
2. This program will provide information and support necessary for the member to make positive lifestyle changes, which will result in healthy eating habits and weight reduction.
3. This program includes the use of food diaries and nutritional counseling.

Physician Signature **X**	**Date Signed** *(MM/DD/YYYY)*
Primary Weight Loss Program Contact Name	**Phone Number**

IMPORTANT NOTE: This benefit is limited to eligible members of the UAS Health Plan administered by UMR and is contingent upon the member meeting specified requirements, including prior authorization by UMR Utilization Management.

Fax to: UMR Utilization Management
UAS Weight Loss Program

FAX: 866-912-8464 **PH:** 888-438-6105

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