

State of Mississippi
State and School Employees' Health Insurance Plan
Obesity Treatment Program Application

Checklist for completing the 2010 *Obesity Treatment Program Application*.

This application must be completed by you (Participant) and your physician.

- Complete, sign, and date Section A. Your Member ID is located on your State and School Employees' Health Insurance Plan identification card.
- You must be a participant in the Plan for at least twelve (12) consecutive months prior to June 1, 2010.
- You must have completed the 2010 HealthQuotient (HQ) health risk assessment prior to submission of the application. Go to www.webmdhealth.com/mississippi to complete the HQ.
- Your physician must complete Section B and sign the Attestation.
- THE PAST TWO (2) YEARS MEDICAL RECORDS FROM THE PHYSICIAN COMPLETING THE APPLICATION MUST BE SUBMITTED WITH YOUR APPLICATION.**

Your completed application and medical records must be faxed to: (877) 492-4746 (toll-free)

Your completed application and medical records must be received on or before June 1, 2010.

Incomplete applications will not be considered for participation in the OTP. Prior to submitting your application, be sure that all information is complete for all sections.

Should you have any questions, please call the Office of Insurance at (601) 359-3411 or toll-free (866) 586-2781.

Here's what will happen:

- From the qualified applicants, one hundred (100) participants will be randomly selected by an independent consulting firm.
- You will be notified by mail by July 1, 2010, whether you are selected to participate in the Obesity Treatment Program.

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APPLICATION MUST BE RECEIVED ON OR BEFORE June 1, 2010.

Section A: Information to be completed by Participant (PLEASE PRINT)				
Last Name:	First Name:	Middle Initial:	Member ID:	
Mailing Address:	City:	State:	Zip:	
County:	Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Home Phone:	Work Phone:	Cell Phone:	Email Address:	

I hereby apply to participate in the Mississippi State and School Employees' Health Insurance Plan's (Plan) Obesity Treatment Program (Program). I agree to comply with any and all terms and conditions of the Program including, but not limited to, participation and reporting requirements. This includes participation in a twelve (12) month post-surgery case management program administered by the Plan's medical management vendor. I agree to comply with any and all requests by the Plan for post-surgical medical and productivity information, with such agreement to survive my participation in the Plan. I understand and acknowledge that the terms and conditions of the Program may be amended at any time, and agree to abide by such amendment(s). I agree that information provided on this application may be used by the Plan for identification for alternate programs available to me. I certify that I have been a participant in the Plan for at least twelve (12) consecutive months prior to June 1, 2010. I certify that I have completed the Plan's 2010 HealthQuotient health risk assessment. I agree to provide my personal and medical information to the Plan and/or the Plan's medical management vendor, if requested.

Participant's Signature: _____ Date: _____

Section B: Participant Medical Information - To be completed by Physician		
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Current Height (inches):	Current Weight (lbs):	Lowest weight (lbs) within last 2 years:
Body Mass Index (BMI) $\frac{\text{Weight (lbs)}}{\text{Height (inches)}^2} \times 703$	Current BMI:	Lowest BMI within last 2 years:

I certify that this individual has attained physical maturity (at least 18 years of age) and has reached full expected skeletal growth as verified by the attached medical records.
Yes _____ No _____

I certify that this individual has actively participated in two (2) or more physician-supervised weight loss attempts, each lasting at least three (3) months in duration within the past two (2) years as verified by the attached medical records. Yes _____ No _____

I certify that this individual's lowest BMI for the last two (2) years has been ≥ 40 as verified by the attached medical records. Yes _____ No _____

I certify that this individual's lowest BMI for the last two (2) years has been 35 – 39.9 as verified by the attached medical records. Yes _____ No _____

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Section B: Participant Medical Information - To be completed by Physician (Continued)

I certify that this individual has been diagnosed with the following:

Please check all that apply.

- Type 2 Diabetes
- Hypertension Clinically unmanageable hypertension = systolic BP at least 140 mmHg or diastolic BP 90 mmHg or >, or if individual is taking antihypertensive agents
- Coronary Artery Disease
- Pulmonary Hypertension
- Obesity related Cardiomyopathy
- Severe Obstructive Sleep Apnea Apnea/hypopnea index or AHI = 30
- Gastro-esophageal reflux disease
- Asthma

PHYSICIAN CONTACT INFORMATION AND ATTESTATION (PLEASE PRINT)

Physician Name:

Office Address:

City:

State:

Zip:

Office Phone Number:

Office Contact:

Specialty:

Medical License Number:

Email Address:

I hereby attest that all information provided by me on this application is true and accurate to the best of my knowledge. I have submitted, with this application, all supporting clinical documentation required to verify the accuracy of the information provided by me and understand that failure to submit such information will preclude the Participant from consideration in the Obesity Treatment Program. I understand that all clinical information provided will be reviewed by the Plan's medical management vendor. I agree to timely submit any additional information that may be requested. I understand that submission of misleading and/or false information may subject me to civil and/or criminal penalties pursuant to State law.

Physician's Signature: _____ Date: _____