Preventive Health Assistance (PHA) Agreement Form
Adult – Weight Management

Participant's Name: MID#:

Completion of this form does not guarantee your request for services will be approved. You must return this form with all blanks filled in before you can be approved for services. Medicaid **will <u>not</u>** pay for transportation services related to the Preventive Health Assistance (PHA) benefit.

Health Care Provider Section

Step 1 – *To be completed by your doctor, physician's assistant, or nurse practitioner*

I have completed a wellness examination of _____and he/she is healthy enough to participate in a weight management program. **Height**:_____ **Weight**:_____

_____ _____(**Please return form to patient**)
Physician's Name Physician's Signature

_____ _____
Phone Number Date

Participant/Guardian Section

Step 2 – *To be completed by the participant or guardian*

I have reviewed the terms of the PHA Program and have talked with my doctor.

_____ _____ _____
Participant's Signature Date Phone Number

Step 3 – *After you decide what program to use, take this form to a PHA participating weight management program and have them sign below, stating they will agree to provide services to you.* ***If you sign a contract before you receive a prior approval of services from the PHA Unit, you may be responsible for the full amount of the contract.***

PHA Weight Management Provider Section

Step 4 – *To be completed by the weight management program representative*

_____ _____ _____
Weight Management Provider Provider Number Representative Name

_____ _____ _____
Address Phone Number Date

Step 5 – ***Mail or fax this form back to us at the address below. A notice of decision letter regarding your application for the PHA benefit will be mailed to you.***

Contact Information

Molina Medicaid Solutions Attn: PHA Department
PO Box 70081
Boise, ID 83707
PHA Toll-Free Phone #: 1-877-364-1843
Fax #: 1-877-845-3956