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

PATIENT'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 not** pay for transportation services related to the Preventive Health Assistance (PHA) benefit.

STEP 1 – To be completed by your doctor, physician's assistant, or nurse practitioner.
Health Care Provider Section:

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

_____ X_____**(PLEASE RETURN FORM TO PATIENT)**
Physician's Name **Physician's Signature**

Height: _____
Weight: _____
DOB: _____

_____ _____
Phone Number Date

STEP 2 – To be completed by the participant or guardian
Participant/Guardian Section:

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

X_____ _____ _____
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.**

STEP 4 – To be completed by the weight management program representative PHA Weight Management Provider Section-(**Where you'd like to go to exercise or learn to manage your weight**)

X_____ _____ _____
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.**

Molina Medicaid Solutions
Attn: PHA Department
PO Box 70081
Boise, ID 83707
FAX: 1-877-845-3956 / Toll-Free Phone #: 1-877-364-1843
www.medicaid.idaho.gov