PREVENTIVE HEALTH ASSISTANCE (PHA)
WEIGHT MANAGEMENT AGREEMENT FORM *INSTRUCTIONS*

ALL SECTIONS MUST BE COMPLETED FOR PROCESSING

INSTRUCTIONS:

All 3 sections of the form must be completed for processing. Incomplete forms will be denied.

***If you sign a contract with a weight management facility before you receive approval for services from the PHA unit you may be responsible for the full amount of the contract.**

Section 1: Contact your primary care provider to initiate the PHA application process. You will need to visit your provider to have your height and weight measured and documented. Section 1 of the agreement form must be filled out and signed by your primary care provider. Medicaid will verify this with your providers office during the review process.

Section 2: Pick a PHA weight management authorized facility. You can find a list of participating facilities on the PHA weight management website at www.MedUnit.DHW.Idaho.gov. Fill in the information pertaining to the weight management facility you would like to attend or take the agreement form to the facility and have their staff member fill it out.

Section 3: Sign and date verifying you have discussed your weight management plans with your provider and agree to the Preventative Health Assistance Program guidelines.

Send the completed form to the Medical Care Unit at the PHA fax number listed at the top of the agreement form. *Before sending the PHA weight management agreement form please verify with the Department of Health and Welfare that your mailing address is correct. You can call self-reliance at (877) 456-1233 to check and update your mailing address and contact information.

After the Medical Care Unit reviews and processes your request, you will receive a letter in the mail with the determination of your PHA eligibility. If approved there will be a voucher attached to the letter that you need to take to the weight management facility the Department approved.

Medicaid **WILL NOT** pay for transportation services OR for additional charges more than the approved PHA benefit.

If you sign a contract with a weight management facility before you receive approval for services from the PHA unit you may be responsible for the full amount of the contract.

For additional questions you can contact the PHA weight management program at (877) 364-1843 or email questions to MedicaidPHAProgram@DHW.Idaho.gov

IDAHO MEDICAID PREVENTIVE HEALTH ASSISTANCE (PHA)
WEIGHT MANAGEMENT AGREEMENT FORM

*****ALL SECTIONS MUST BE FULLY COMPLETED FOR PROCESSING*****

Send the completed form in by fax to: 877-845-3956
Or by Mail to:
Medical Care Unit
Attn: PHA Department
PO BOX 70081
Boise, ID 83707

Medicaid **WILL <u>NOT</u>** pay for transportation services OR for additional charges more than the PHA benefit. If you sign a contract with a weight management facility before you receive approval for services from the PHA unit you may be responsible for the full amount of the contract.

Section 1: To be completed by your primary care provider only (verified during the review process)

PRIMARY HEALTHCARE PROVIDER SECTION

I have completed a wellness examination on my patient listed below. I have determined that he/she is healthy enough to participate in a weight management program and that he/she is:

- ✓ Eligible for Medicaid
- ✓ Is over the age of 5 years
- ✓ Meets the PHA weight management criteria guidelines:
  - Adults: Has a body mass index (BMI) more than 30 or less than 18.5
  - Children: Is underweight (below the 5th percentile), overweight or obese (above 85th percentile) based on the CDC criteria for children

I have listed his/her recent height, weight and BMI for adults or Percentage for children below

Patient's Name:	Medicaid ID#:	DOB:

Height (inches or ft.):	Weight (lbs.):	Adult BMI or Child Percentage:

Physician's Name Printed:	Physician's Signature:	Date:	Physician's Phone #:

Section 2: Chosen Participating Facility (can be completed by participant)

WEIGHT MANAGEMENT PROGRAM FACILITY SECTION

Participating Facility Name:	Facility Address:	Facility Phone #:

Section 3: To be completed by the participant or the participant's guardian:

PARTICIPANT OR GUARDIAN SECTION

I have reviewed and agree to the PHA weight management program guidelines and I have talked with my physician about my weight management plans and goals.

Participant's Medicaid ID #:	Phone Number:

Participant's or Guardian's Signature:	Date:

The status of a request may be checked by calling the PHA program at 877-364-1843 or by emailing the program at MedicaidPHAProgram@DHW.Idaho.gov.
More information can be obtained at www.MedUnit.DHW.Idaho.gov

REV 04/2019