Molina Apple Health (Medicaid)
Bariatric Surgery Program
Extension request for Stage II

Fax this completed form and required documentation to (800) 767-7188

Section 1: General information		
Provider information		
Name of Provider:		
Provider NPI:	Phone:	Fax:
Member information		
Member Name:	DOB:	
Member Phone:	Molina Member ID:	

Section 2: Program extension information	
Stage I/II Authorization #:	
Reason for extension request:	☐ Unable to lose 5% of his or her initial body weight ☐ Delay due to additional testing ☐ Major health issues ☐ Other, please specify ____________
Current weight (lbs):	Date:
Number of completed Registered Dietician visits:	
All extension requests must include supportive documentation and a summary detailing medical issues or barriers.	
Amount of time requested:	☐ 6 months ☐ 3 months