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

Participant's Name: **Medicaid ID#:**

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:

HEALTHCARE PROVIDER SECTION				
I have completed a wellness examination on my patient listed below. He/she is healthy enough to participate in a weight management program and I have listed his/her recent height and weight below.				
Patient's Name	Date of Birth	Height	Weight	Physician's Phone #
Physician's Name		Physician's Signature		Date

STEP 2: To be completed by participant or guardian:

PARTICIPANT OR GUARDIAN SECTION		
I have reviewed the terms of the PHA program and have talked with my doctor about managing my weight.		
Participant's Name	Participant's Signature	Date

STEP 3: Take this form to the PHA participating weight management provider of your choice and have them sign below stating they agree to provide services to you. **If you sign a contract before you receive prior approval of services from the PHA unit you may be responsible for the full amount of the contract.**

WEIGHT MANAGEMENT PROGRAM SECTION		
Weight Management Provider	Address	Phone #
Provider Number	Representative Name	Date

STEP 4 – 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
Phone: 1-877-364-1843
Fax: 1-877-845-3956
MedicaidPHAProgram@dhw.idaho.gov