THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

BARIATRIC SURGERY PROGRAM APPLICATION

Instructions: 1) Type or write directly into form – complete all pages. 2) Save form and print a copy for your records. 3) Email saved form to: ObesitySurgery@osumc.edu or mail/drop off a copy to Martha Morehouse Medical Plaza, 2050 Kenny Rd, 2nd Floor Pavilion, Suite 2500, Columbus OH, 43221.

Date:	

SELF											
Last Name:		First:		MI:		Maiden:					
Address:											
City:		State:		Zip:							
Home #:		Cell #:		Work #:							
Date of Birth:		SSN#:									
Gender:	☐ Male	☐ Female									
Marital Status:	☐ Married	☐ Divorced	☐ Widowed	☐ Separated	☐ Never Married						
Race:	☐ White	☐ Hispanic	☐ Asian	☐ Native American / Alaskan Native							
	☐ African American		☐ Other:								
Employer:											
Current Weight:											
Current Height:											

YOUR PRIMARY CARE PROVIDER					
Physician:					
Address:					
City:		State:		Zip:	
Phone:		Fax:			

PRIMARY INSURANCE INFORMATION					
Primary Insurance Co:					
Address:					
City:		State:		Zip:	
Policy Holder's Name:					
Relationship to Patient:					
Policy #:		Group / Plan #:			
Customer Service Phone:					
Provider Inquire / Pre-Certification Phone:					
Contact Person:					
Is gastric bypass and/or lap-band for "morbid obesity" a covered benefit?			☐ Yes	☐ No	
If you have EVER had bariatric surgery, is REVISION SURGERY a covered benefit:			☐ Yes	☐ No	

SECONDARY INSURANCE INFORMATION					
Secondary Insurance Co:					
Address:					
City:		State:		Zip:	
Policy Holder's Name:					
Relationship to Patient:					
Policy #:		Group / Plan #:			
Customer Service Phone:					
Provider Inquire / Pre-Certification Phone:					
Contact Person:					
Is gastric bypass and/or lap-band for "morbid obesity" a covered benefit?			☐ Yes	☐ No	
If you have EVER had bariatric surgery, is REVISION SURGERY a covered benefit:			☐ Yes	☐ No	

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity.

I understand that I am financially responsible for any balance not covered by the insurance carrier(s).

I also request that payment of benefits from my policy _____ (Medigap/other) be paid directly to the billing entity until otherwise notified.

Signature: _____

Signature of Parent (if minor): _____

MEDICAL HISTORY

TOBACCO PRODUCTS:

Do you smoke?	☐ Yes	☐ No		
If NO, do you use any tobacco products?		☐ Yes	☐ No	
Have you EVER used tobacco products?		☐ Yes	☐ No	
If YES, what kind?			How often?	
What year did you start?			Quit date:	

ALCOHOL CONSUMPTION:

How much of the following do you drink per week?			
Mixed Drinks (1oz/drink)			
Beer (12oz)			
Wine (6oz/glass)			
Do you have a history of alcohol abuse?	☐ Yes	☐ No	
Have you ever felt or been told that you have a drinking problem?		☐ Yes	☐ No

ALLERGIES:

Are you allergic to any drug, food or substance?	☐ Yes	☐ No		
If YES, list each allergy and reaction	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	

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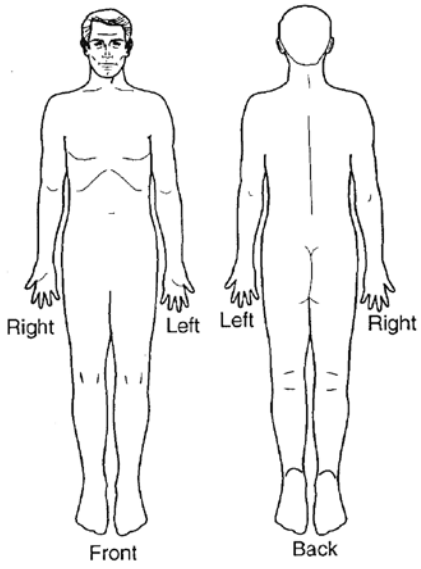
MEDICATION LIST:

Medication Name	Dosage	Frequency	Why do you take it?

Use C-PAP or BI-PAP?	☐ Yes	☐ No
Use OXYGEN?	☐ Yes	☐ No
How many liters?		
Hours per day?		

SURGERIES:

Date:	Type of Surgery:	Below, please indicate the location of any surgical incisions (scars from surgeries) that you have.
		

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ILLNESSES / MEDICAL CONDITIONS:

Please mark all illnesses or medical conditions that you and/or your blood relatives have ever had:

	You	Mother	Father	Brother(s)	Sister(s)
High Blood Pressure	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Cancer (list):	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Heartburn / Indigestion / Reflux	☐	☐	☐	☐	☐
Angina / Chest Pain	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
Depression / Anxiety	☐	☐	☐	☐	☐
Bleeding Problems	☐	☐	☐	☐	☐
Clotting Problems	☐	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐	☐

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INSURANCE DISCLAIMER FORM

Many insurance companies have specific requirements that must be met before surgery is approved. The form below must be completed for all insurance companies except Medicare. It will help you to know and understand your benefits.

Instructions:

1. Call the customer service number on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits for weight loss surgery for morbid obesity.
3. Read the questions below word for word to get the most accurate information. Please complete all questions and sign the form.
4. Fill out a form for each insurance company if you have more than one. Make as many copies as needed.

Disclaimer:

- The Ohio State University Wexner Medical Center Bariatric Surgery Program is NOT responsible for incorrect information provided by the insurance company.
- Completion of this form does not mean that you are approved for weight loss surgery and does not guarantee payment for services. You will be responsible for any charges that your insurance does not cover.

---------- *Type in the information below BEFORE you call the insurance company.* ----------

Patient's Name:	
Patient's Date of Birth:	
Insurance Provider:	
ID Number:	
Group Number:	
Subscriber Name:	
Subscriber's Employer:	
Subscriber's Date of Birth:	
Insurance Company Name:	
Member Customer Service Number:	
Date Contacted:	
Name of Customer Service Representative:	

1. **"Hello, my name is: _____**
   I would like to learn about my plan benefits with regard to morbid obesity surgeries, including gastric lap band, gastric sleeve and gastric bypass surgery. Does my policy cover these services or is there an exclusion in my contract?"
   (If there is an exclusion, the rest of the questions do not apply. Stop here!)

2. If you are applying for a revision surgery, ask:
   "Do I have benefits in my policy for a revision of previous weight loss surgery?"
   ☐ Yes ☐ No
   If yes, please verify specific requirements: _____

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3. **"Is The Ohio State University Wexner Medical Center in my network?"**
   ☐ Yes ☐ No

4. **"Are these surgeons in my network?"**
   Dr. Bradley Needleman: ☐ Yes ☐ No
   Dr. Sabrena Noria: ☐ Yes ☐ No

5. **"Does my policy cover services for associated surgery clearances such as cardiac, pulmonary, psychological evaluations and pre-admission testing?"**
   ☐ Yes ☐ No

6. If benefits are allowed, ask the following questions:
   "What is the minimum BMI?" _____
   "If my BMI is Below 40, are there any co-morbidities that I must have to qualify for insurance approval?" (Please list)
   _____

7. **"At what level does my policy pay for the following services."** (For example 80%, 100%)

% of Payment	CPT Code	Diagnosis Code
	43846 Open Revision	E66.01
	43770 Gastric Lapband	E66.01
	43775 Gastric Sleeve	E66.01
	43644 Gastric Bypass	E66.01

8. **"How much is my deductible?"** _____

9. **"What is my office visit co-payment?"** _____

10. **"Do I need to complete a medical weight management program before surgery is approved?"**
    ☐ Yes ☐ No
    If yes, ask "how long? ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

11. **"Does this program need to be supervised by a physician?"**
    ☐ Yes ☐ No
    - If yes, please plan to make monthly appointments with your family doctor.
    - Ask your doctor to include height, weight and recommendations for a diet and exercise plan in each visit note.
    - Please note: Based on your clinical evaluations, an education program may need to be completed in addition to any insurance requirements.

Patient Signature: _____ Date: _____