SANFORD HEALTH

Millions of people struggle with weight loss. If you've tried dieting, portion control and an exercise program, but still can't get results, surgery can provide an excellent alternative for sustained weight control.

At Sanford Health Bismarck we perform both gastric bypass and sleeve gastrectomy, both vary in how they are performed, their recovery time and who is best suited for them. You can review these differences prior to information session online at sanfordhealth.org/weightlosssurgery.

Steps to being scheduled for a consultation

- **Attend an online information session------**
- **Held 2nd Tuesday of each month dates can be found online https://www.sanfordhealth.org/classes-and-events/weight-loss-surgery-informational-session**
- **Get a referral for bariatric surgery** from your primary care provider if you have not already. If you do not have a provider we recommend you establish care with one.
- **Call your insurance company** and make sure your policy has benefits for bariatric surgery.

  The basic requirements for most insurance is **BMI of 40 or above or BMI of 35-39 with qualifying** health problem related to obesity. We can help you determine if you meet medical necessity for your insurance. In order for us to determine if you fit your insurance companies medical policy guidelines for coverage we will need to review your medical records.

- **Return Registration paperwork** –

  Bismarck Weight Loss Surgery Questionnaire packet and authorization for disclosure of protected health information form(s).

List all providers that you see for medical care in the last 3 years. If you have had any major abdominal surgeries (hernia repairs, lap band removals, etc.) we will need operative notes please list these on the disclosure form.

We will gladly fax the enclosed medical records disclosure forms but they need to be include at least a phone number of the facility. If all your records are through Sanford we do not need disclosure forms.

If you prefer paperwork be mailed please call 323-5300 to request paperwork be mailed to you.

Drop off or Mail to: Sanford WLS clinic 222 n 7th st Bismarck, ND 58501 or **FAX:** 701-323-5886.

Our nurse coordinator will contact you after we have obtained and reviewed of your records. Nurse coordinator will help you schedule for consultation, required 3 nutrition appointments with our dietitian some insurance may require more, and a psychological evaluation. Do not schedule your own psychology evaluation it will need to be with one of our approved providers.

We know that this is a long and involved process, but we encourage you not to become frustrated. These are necessary steps to ensure the safety and long-term success of your procedure. Plus, you will have the rest of your life to enjoy the benefits.

Thank you for choosing Sanford Health Bismarck. We hope to see you at our upcoming informational session. If you have any questions, you may reach nurse coordinator directly (701) 323-5530.

Sincerely,

Sanford Health Bismarck Weight Loss Surgery Team

Bismarck Weight Loss Surgery Questionnaire Packet

Consent

Date: _____

I give my verbal and written consent for Sanford Health to release all of the information of my past medical history, including psychological evaluations, supervised and unsupervised weight loss programs, etc.

All information regarding my past and present medical history may be copied and released to my insurance company, Medicare, Medicaid, etc. for pre-authorization for gastric bypass/lap band surgery due to morbid obesity.

Patient Signature: _____

May we leave a message on your answering machine at work or home? Yes No

May we leave a message with your spouse or significant other? Yes No

Patient Signature: _____

Insurance Information

Insurance Company Name: _____

Policy Number: _____

Group Name: _____

Group Number: _____

bismarck.sanfordhealth.org/weightlosssurgery

Bismarck Weight Loss Surgery Questionnaire Packet

Date: _____ **Name:** _____

Nickname: _____ **Allergies:** _____

Sex: Male Female **Ethnic Origin:** ☐ Caucasian ☐ African American ☐ Asian ☐ Native American

☐ Hispanic ☐ Other: _____

SSN#: _____ **DOB:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Height:** _____ **Weight:** _____

Doctor referred by: _____

Marital Status: ☐ Married ☐ Single ☐ Separate ☐ Divorced ☐ Widowed

Education: _____ **High School Graduate:** _____

Years in college: _____ **Years in post grad:** _____

Occupation: _____

Employment (Full time or Part time): _____

Present: _____ **Past:** _____

Please indicate how much and how often you use the following substances. If past use, please make note of this.

Nicotine (tobacco - chew, cigar or cigarettes, vape or e-cigarettes): _____

Alcohol: _____ Caffeine: _____

Recreational/street drugs: _____

Bismarck Weight Loss Surgery Questionnaire Packet

Medical History

Please list any surgical procedures with either year or your age at procedure:

Surgery	Year

Hospitalizations for reasons other than surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____

Bismarck Weight Loss Surgery Questionnaire Packet

Family History

Please answer the following questions regarding your family history.

History includes age or age at death, any medical problems such as diabetes, heart trouble, high blood pressure, stroke, epilepsy, tuberculosis, cancer, and cancer type.

Mother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Father: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Brother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Sister: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Maternal Grandmother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Maternal Grandfather: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Paternal Grandmother: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Paternal Grandfather: Age: _____ Any medical problems: _____

Cancer: Y / N Type: _____ Living: Yes No Cause of death: _____

Bismarck Weight Loss Surgery Questionnaire Packet

Spouse: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Son: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Son: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Son: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Daughter: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Daughter: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Daughter: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

<u>Other blood relative not listed above:</u>

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Relative: Age: ________ Any medical problems: ________________________________

Cancer: Y / N Type: ____________________ Living: Yes No Cause of death: ________________

Bismarck Weight Loss Surgery Questionnaire Packet

Current Medical Condition

Please check yes or no for those that apply.

High blood pressure	☐ Yes	☐ No
On medication	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Pulmonary disease/asthma/COPD	☐ Yes	☐ No
Seizure disorder	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
If Yes, what kind: _____		
Depression	☐ Yes	☐ No
Mental illness	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Hx of transplant	☐ Yes	☐ No
If Yes, what kind: _____		

Other medical diagnosis (i.e. liver disease):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list all current medications, including all over-the-counter pain medication (write down medication name, dosage, frequency, and when taken):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Bismarck Weight Loss Surgery Questionnaire Packet

Eyes

Blurring	☐ Yes	☐ No
Double vision	☐ Yes	☐ No
Irritation/infections	☐ Yes	☐ No
Eye pain	☐ Yes	☐ No
Spots or floaters	☐ Yes	☐ No
Changes in vision	☐ Yes	☐ No
Glasses	☐ Yes	☐ No
Contacts	☐ Yes	☐ No

General

Fevers	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No

Ears/Nose/Throat

Earaches	☐ Yes	☐ No
Discharge from ears	☐ Yes	☐ No
Ringing in ears	☐ Yes	☐ No
Decrease in hearing	☐ Yes	☐ No
Hearing aides - Circle one: Right Left Both		
Recurrent head colds	☐ Yes	☐ No
Sinus troubles	☐ Yes	☐ No
Dysphagia (difficulty swallowing)	☐ Yes	☐ No
Change in taste	☐ Yes	☐ No
Change in smell	☐ Yes	☐ No
Persistent hoarseness	☐ Yes	☐ No
Recurrent sore throats	☐ Yes	☐ No
Recurrent sores in mouth	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No
Soreness or bleeding from gums when brushing	☐ Yes	☐ No
Dentures - Circle one: Top Bottom Both		
Partials - Circle one: T-B T-B Both		
Permanent bridges or implants	☐ Yes	☐ No

Bismarck Weight Loss Surgery Questionnaire Packet

Cardiovascular

Chest pain	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Fainting spells	☐ Yes	☐ No
Shortness of breath:		
Walking several blocks	☐ Yes	☐ No
One flight of stairs	☐ Yes	☐ No
When laying down	☐ Yes	☐ No
Wake up at night	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Swelling of hands or feet	☐ Yes	☐ No
Varicose veins	☐ Yes	☐ No
Heart disease	☐ Yes	☐ No
Circulation problems	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Cough when lying down	☐ Yes	☐ No
Sleep on more than one pillow	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Cough up blood	☐ Yes	☐ No
Wheezing or asthma	☐ Yes	☐ No

Allergic/Immunologic

Hay fever	☐ Yes	☐ No
Recurrent infections	☐ Yes	☐ No
HIV/Exposure	☐ Yes	☐ No

Endocrine

Heat intolerance	☐ Yes	☐ No
Cold intolerance	☐ Yes	☐ No
Hot flashes	☐ Yes	☐ No
Brittle nails	☐ Yes	☐ No
Change in skin texture	☐ Yes	☐ No
Change in hair texture	☐ Yes	☐ No

Hematologic/Lymphatic

Abnormal bruising or bleeding	☐ Yes	☐ No
Enlarged lymph nodes	☐ Yes	☐ No
Blood transfusion or plasma transfusion	☐ Yes	☐ No

Sleep apnea diagnosed: _____ Symptoms only no testing: _____

CPAP: _____ Bipap: _____ Other: _____

Skin

Rashes	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Dryness	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No

Bismarck Weight Loss Surgery Questionnaire Packet

Gastrointestinal

Stomach pain or cramping	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
If Yes, how do you treat? _____		
Nausea or vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
If chronic, has it been evaluated?	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
If chronic, has it been evaluated?	☐ Yes	☐ No
Bleeding from rectum	☐ Yes	☐ No
If Yes, has this been evaluated?	☐ Yes	☐ No
Vomiting of blood	☐ Yes	☐ No
Hemorrhoids	☐ Yes	☐ No

Genitourinary

Urinary frequency _____ times per day		
Do you feel like you empty your bladder?	☐ Yes	☐ No
Pain with urination	☐ Yes	☐ No
Difficulty starting urination	☐ Yes	☐ No
Get up at night to urinate	☐ Yes	☐ No
Urinate more than before	☐ Yes	☐ No
Urinate less than before	☐ Yes	☐ No
Blood in your urine	☐ Yes	☐ No
Loss of urine with coughing or sneezing	☐ Yes	☐ No
Males: Discharge from penis	☐ Yes	☐ No
Females: Vaginal discharge	☐ Yes	☐ No
Painful periods	☐ Yes	☐ No
Polycystic ovarian disease	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No

How many pregnancies? _____

Live births: _____

Still births: _____

Miscarriages: _____

Cesarean sections: _____

Bismarck Weight Loss Surgery Questionnaire Packet

Neurological

Headaches	☐ Yes	☐ No
Migraine headaches	☐ Yes	☐ No
Dizzy spells	☐ Yes	☐ No
Paralysis	☐ Yes	☐ No
Change of sensation in hands or feet	☐ Yes	☐ No
Tingling of hands or feet	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Head injuries	☐ Yes	☐ No
Knocked unconscious	☐ Yes	☐ No

Musculoskeletal

Back pain/backaches	☐ Yes	☐ No
If Yes, has it been evaluated? _____		
Joint pain: knees, hips, or ankles	☐ Yes	☐ No
Joint swelling	☐ Yes	☐ No
Muscle spasms	☐ Yes	☐ No
Leg cramps	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Assistive devices: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Prosthesis

☐ Other: _____

Psychiatric

Depression	☐ Yes	☐ No
Substance abuse or addiction (drugs or alcohol)	☐ Yes	☐ No
If yes, have you been treated for this? _____		
Anxiety	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Suicidal ideation	☐ Yes	☐ No
Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes	☐ No
Bipolar disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Paranoia	☐ Yes	☐ No
Hallucinations	☐ Yes	☐ No

Other: _____

Bismarck Weight Loss Surgery Questionnaire Packet

Dieting History Form

Name of diet plan	List year(s) on plan	Wt. loss	Wt. gain	Additional info
Diet (cutting back)				
Liquid diets (Slim Fast)				
Weight Watchers				
Overeaters Annon.				
Tops				
Diet Center				
NutriSystem				
Jenny Craig				
Diet Pills OTC (i.e. Dexatrim)				
Diet Pills Rx				
LA Weight Loss				
Acupuncture				
Hypnosis				
Body Connection				
Optifast				
Medifast				
Atkins (protein diet)				
South Beach				
Mayo Clinic				
Phentermine				
Phen Fen				
Redux				
Herbal tea				
Herbal Life				
Calorie counting				
Fat free diets				
Vegetable diets				
Exercising				
Richard Simmons diet				

How many years have you been obese? _____

Please be specific with when you were on the plan, how much weight you lost and how much gained.

The last 3-5 years are most important.

Bismarck Weight Loss Surgery Questionnaire Packet

Epworth Sleepiness Scale

This questionnaire will help your physician to measure your general level of daytime sleepiness.

Name: _____ Date of birth: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the *most appropriate number* for each situation:

0 = would never doze
1 = slight chance to dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Do you snore?	Yes	No		
Have you been told you stop breathing when sleeping?	Yes	No		

Authorization for Disclosure of Protected Health Information

SANFORD

Patient Name: _____ **Date of Birth** _____

Full Address: _____

Phone Number: _____

Maiden/Previous Names: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility: _____

Address: _____

City/State/Zip _____

Phone: _____

Release Information To:

Name/Facility: Sanford Health WLS Clinic -Bismarck

Address: 222 N. 7th St. Mail Route 20776

City/State/Zip Bismarck, ND 58501

Phone: Fax: 701-323-5886

Purpose of Release:

- ❑ Continuing Medical Care
- ❑ Insurance Claim
- ❑ Application for Insurance
- ❑ Work Comp
- ❑ Disability Determination
- ❑ Personal
- ❑ Other: _____

Delivery Method: Date information desired by: ASAP

Release Format (Check 1 of 3 options only):

1. ☒ Paper via ☒ Mail **OR** ❑ Pick Up **OR** ☒ Fax (*as appropriate*) **Fax # :** 701-323-5886
2. ❑ USB ❑ Mail **OR** ❑ Pick Up
3. ❑ Electronic via *My Sanford Chart* Patient Portal
   ❑ Release to ALL *My Sanford Chart* Proxies

Information to be Released: Last 3 years

Service Dates: From: _____ To: _____ **OR** ❑ all future records until this authorization expires

NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☒ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

- ❑ Discharge Summary
- ☒ Psychological Evals/Assmts
- ☒ Lab / Pathology Reports X1year
- ❑ Billing Statements
- ❑ Alcohol/Drug Treatment Records
- ❑ ER Records
- ❑ EKG / Cardiology Reports
- ☒ Radiology Images
- ☒ Other: CT Abd or Upper GI studies, any xrays *(charge may apply)*
- ☒ History & Physical
- ❑ Immunization Records
- ❑ Radiology Reports
- ☒ Clinic Visit Notes x3 yr
- ☒ Operative Reports
- ❑ Entire Medical Record

Ht/Wt 5 years histoty

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If not patient):	

Authorization for Disclosure of Protected Health Information

SANFORD

Patient Name: _____ **Date of Birth** _____

Full Address: _____

Phone Number: _____

Maiden/Previous Names: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

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City/State/Zip

Phone:

Release Information To:

Name/Facility: Sanford Health WLS Clinic -Bismarck

Address: 222 N. 7th St. Mail Route 20776

City/State/Zip Bismarck, ND 58501

Phone: Fax: 701-323-5886

Purpose of Release:

- ❑ Continuing Medical Care
- ❑ Insurance Claim
- ❑ Application for Insurance
- ❑ Work Comp
- ❑ Disability Determination
- ❑ Personal
- ❑ Other: _____

Delivery Method: Date information desired by: ASAP

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1. ☒ Paper via ☒ Mail **OR** ❑ Pick Up **OR** ☒ Fax (*as appropriate*) **Fax # :** 701-323-5886
2. ❑ USB ❑ Mail **OR** ❑ Pick Up
3. ❑ Electronic via *My Sanford Chart* Patient Portal
   ❑ Release to ALL *My Sanford Chart* Proxies

Information to be Released: Last 3 years

Service Dates: From: _____ To: _____ **OR** ❑ all future records until this authorization expires

NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☒ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).*

- ❑ Discharge Summary
- ☒ Psychological Evals/Assmts
- ☒ Lab / Pathology Reports X1year
- ❑ Billing Statements
- ❑ ER Records
- ❑ EKG / Cardiology Reports
- ☒ Radiology Images
- ☒ Other: CT Abd or Upper GI studies, any xrays *(charge may apply)*
- ☒ History & Physical
- ❑ Immunization Records
- ❑ Radiology Reports
- ☒ Clinic Visit Notes x3 yr
- ☒ Operative Reports
- ❑ Entire Medical Record

❑ Alcohol/Drug Treatment Records Ht/Wt 5 years histoty

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_____Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be re-disclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature *(required)*:	**Date Signed** *(required)*:
Printed Name of Person Signing (If not patient):	

SANFORD HEALTH

Insurance Coverage Worksheet

Are you interested in weight-loss surgery? Find out if it's covered by your insurance. Please call your insurance and ask the following questions. The phone number to contact your insurance is usually on the back of your insurance card.

1. **Does my policy cover bariatric surgery? Y___ N____**

2. **What procedures are covered?**

(Mark all that apply).

The primary diagnosis will be Morbid Obesity E66.01

___CPT code 43644 Gastric Bypass

___CPT code 43775 Sleeve Gastrectomy

3. **What do I need to have to qualify for surgery?**
   ___BMI >40_____
   ___BMI >35 with specific comorbid conditions ie : diabetes, uncontrolled high blood pressure or cholesterol, sleep apnea or certain others may be covered in some plans.

4. **Do I have to go to a specific hospital for surgery?** _____
5. **Name of customer service representative:** _____
6. **Call reference number:** _____
7. **Date of phone call:** _____

Once you verify that your insurance plan will cover bariatric surgery return your questionnaire and medical records release.

We can help you determine if you meet insurance coverage guidelines for medical necessity when we get your records.

Please don't hesitate to give our office a call if you have any questions.