THE Bariatric Center
AT GEORGETOWN COMMUNITY HOSPITAL

INSURANCE REVIEW FORM

(This form is to help you determine whether or not your insurance policy has benefits for weight loss surgery. Please follow the instructions below. **This form does not need to be completed for Medicare.**)

Instructions:

1. Fill in Section **"A"** of this form, using the information found on your current insurance card.
2. Call the customer service number located on your insurance card and speak to a customer service representative.
3. Tell the representative that you would like to check policy benefits.
4. Follow the script in Section **"B"** below to get the necessary information. The questions provided to you should be read word for word to the customer service representative to insure the most accurate information possible.
5. **Do not leave any fields blank.**
6. **Sign the form on the back. Failure to do so will result in the form being returned.**
7. Once complete, return this form, along with a copy of your insurance card(s), to our office.
8. Please also make sure that you submit your patient profile packet via mail or internet.
9. If you have more than 1 insurance, a form must be filled out for each insurance. Therefore, make as many copies as needed before writing on this form.
    a. Medicare patients: You do not have to fill out a form for Medicare but if you have any other insurance, a form must be filled out. You must complete this form if you have a Medicare supplement plan.
    b. Medicaid patients: Our program does not accept Medicaid.

Disclaimer:

- The Bariatric Center at GCH is not responsible for incorrect information the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form does not mean that you are approved for weight loss surgery. A surgical pre-approval can only be obtained once the necessary documentation is sent to the insurance company by The Bariatric Center at GCH.

Section A. Fill in this information before you call the insurance company. **Please write clearly.**	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	

Section B.

#	Question for Representative	Answer from Representative
1	Please look in my 2008 certificate of coverage. Do I have benefits for weight loss surgery for morbid obesity if medically necessary?	☐ **Yes** (Continue with this form.) ☐ **No** (Complete #s 2, 23, & 24 then end the call. **See explanation below
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	

****An exclusion occurs when the policy purchased does not come with weight loss surgery benefits. If the insurance company representative told you that you have a contract exclusion in your policy that means that surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying they are not going to pay for it. A contract exclusion can only be overturned if you have a self-funded policy.**

3	What is the effective date of my policy?	
4	What is the calendar year renewal date?	
5	Am I subject to pre-existing?	
6	If yes, what is the end date of the pre-existing clause?	
7	Is a referral required?	
8	What is the deductible per calendar year?	
9	How much have I met towards my deductible?	
10	What is the maximum out of pocket per calendar year?	
11	How much have I met towards my maximum out of pocket?	
12	Is the deductible applied to the maximum out of pocket?	
13	What is the co-insurance percent for my policy?	
14	What is my inpatient surgical copay / co-insurance to the doctor?	
15	What is my outpatient surgical copay / co-insurance to the doctor?	
16	What is my inpatient surgical copay / co-insurance to the hospital?	
17	What is my outpatient surgical copay / co-insurance to the hospital?	
18	What is my outpatient diagnostic copay / co-insurance to the hospital (routine labs and x-rays)?	
19	What is my copay for a primary care office visit?	
20	What is my copay for a specialist office visit?	
21	What is the fax number for pre-determination?	
23	Name of the representative	
24	Date you spoke to representative	
25	**If you have an exclusion in your policy, would you like to self pay for surgery? If yes, we will proceed with your process. If no, your process will be stopped.**	**□ Yes** **□ No**

By signing below, I certify the following:

- **I have read and understand the instructions that were provided to me.**
- **I have read and understand the disclaimer which includes that I am not approved for surgery.**
- **I have spoken to my insurance company and answered the above referenced questions to the best of my abilities.**

Patient Signature: _____ Date: _____

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