PATIENT INFORMATION

BARIATRIC SURGERY INSURANCE VERIFICATION

Name_____ Birthdate_____ Male____ Female____

Address_____ Phone # _____

City_____ State_____ Zip_____

Height_____ Weight_____ BMI_____

PLEASE MARK ALL THAT APPLY TO YOUR MEDICAL HISTORY:

__Asthma
__Cardiomyopathy
__Cardiovascular Disease
__Congestive Heart Failure
__COPD
__Coronary Artery Disease
__Degenerative Joint Disease / DJD
__Diabetes
__Diabetes Type II
__Dyslipidemia
__Edema
__Heart Disease
__Hypercholeserolemia
__Hyperlipidemia
__Hypertension
__Metabolic Syndrome
__Nonalcoholic Fatty Liver Disease / NAFLD
__Osteoarthritis
__Pickwickian Syndrome
__Polycystic Ovarian Syndrome / PCOS
__Pseudotumor Cerebri
__Reflux / GERD
__Renal Failure
__Severe Nonalcoholic steatohepetitis / NASH
__Sleep Apnea / OSA
__Shortness of Breath
__Urinary Incontinence
OTHER:_____
_____
_____

PRIMARY INSURANCE INFORMATION

Company_____ Employer_____

Subscriber Name_____ Subscriber Date of Birth_____

Member ID #_____ Group #_____

Phone # for Providers (located on the back of your card)_____

SECONDARY INSURANCE INFORMATION

Company_____ Employer_____

Subscriber Name_____ Subscriber Date of Birth_____

Member ID #_____ Group #_____

Phone # for Providers (located on the back of your card)_____

AUTHORIZATION TO CONFIRM HEALTH INSURANCE BENEFIT INFORMATION

I authorize Methodist Physicians Clinic to share my medical information relating to my use or need for weight loss surgery with my health insurance plan. This information can include spoken or written facts about my medical condition, including copies of my records from Methodist Physicians Clinic healthcare providers, Methodist Hospital, and / or Methodist Jennie Edmundson Hospital. Methodist Physicians Clinic will use and share this information with my health insurance plan to see if I have coverage and / or benefits for weight loss surgery. This authorization will last for one (1) year after the date I sign this form. If I change my mind before that time, I will contact the Methodist Physicians Clinic Director of Health Information Management in writing and state that I no longer want my personal information shared with my health insurance plan.

I understand this will not change any action taken before I revoke this authorization. I know that I have a right to see or copy the information Methodist Physicians Clinic has given my health insurance plan. I understand that I may refuse to sign this form. My decision to sign this form form will not affect the healthcare treatment at this facility. If I refuse to sign this form I understand this means I will no longer receive assistance from Methodist Physicians Clinic in determining my health benefits for weight loss surgery. I understand that Methodist Physicians Clinic does not promise to find alternate payment options for my weight loss surgery and that I may be required to pay for the cost of my care.

Patient Signature_____

Print Name_____

Date_____

Methodist Physicianc Clinic Bariatric Surgery
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