



INSURANCE VERIFICATION REQUEST FORM

1-800-LAP-BAND (527-2263), Option 3 (phone) • 1-800-711-0810 (Fax)

REQUIRED: Do you have your patient's written consent to release patient identifiable information for the purpose of conducting insurance research?

Yes No (If no, obtain consent from patient before forwarding this request.)

<p>Patient Information</p>	<p>Patient Name: _____ M/F (please circle) Date of Birth: _____ Social Security Number: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Height: _____ Weight: _____ BMI: _____</p>												
<p>Surgeon Information</p>	<p>Surgeon Name: _____ Tax ID#: _____ Specialty: _____ Site Name: _____ Office Contact Name: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Email: _____ NPI #: _____</p>												
<p>Procedure Information</p>	<p>Primary ICD-9 Code: _____ Secondary ICD-9 Code (if applicable): _____ CPT Code 1: _____ CPT Code 2: _____ *Benefits cannot be verified without a Diagnosis and CPT code. Surgery Date: (if scheduled): _____ *Please note, Insurer may take up to 3 weeks to process a Prior Authorization. Site of Service: <input type="checkbox"/> Ambulatory Surgical Center (ASC) <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Hospital Inpatient</p>												
<p>Comorbid Conditions (please check all that apply)</p>	<table border="0"> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Obstructive Sleep Apnea</td> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Osteoarthritis</td> </tr> <tr> <td><input type="checkbox"/> GERD/Heartburn</td> <td><input type="checkbox"/> Pseudotumor Cerebri</td> </tr> <tr> <td><input type="checkbox"/> Hypercholesterolemia</td> <td><input type="checkbox"/> Swelling of the Legs (Edema)</td> </tr> <tr> <td><input type="checkbox"/> Hyperlipidemia</td> <td><input type="checkbox"/> Type 2 Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Hypertension/High Blood Pressure</td> <td><input type="checkbox"/> Urinary Stress Incontinence</td> </tr> </table>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Obstructive Sleep Apnea	<input type="checkbox"/> Depression	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> GERD/Heartburn	<input type="checkbox"/> Pseudotumor Cerebri	<input type="checkbox"/> Hypercholesterolemia	<input type="checkbox"/> Swelling of the Legs (Edema)	<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Hypertension/High Blood Pressure	<input type="checkbox"/> Urinary Stress Incontinence
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<p>Primary Insurance Information</p>	<p>Name of Insurance Company: _____ Address: _____ City, State, ZIP: _____ Phone: _____ Fax: _____ Policyholder's Name: _____ Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____ Group plan #: _____ Employer's Name: _____ Surgeon's Provider # (Required for Medicare or Medicaid): _____ Surgeon's participation with the insurer?: <input type="checkbox"/> Participating <input type="checkbox"/> Non-participating</p>												



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<p>Secondary Insurance Information</p>	<p>Name of Insurance Company: _____ Address: _____ City, State, ZIP: _____ Phone: _____ Fax: _____ Policyholder's Name: _____ Relationship to Patient: _____ Date of Birth: _____ Social Security Number: _____ Group Plan #: _____ Employer's Name: _____ Surgeon's Provider # (Required for Medicare or Medicaid): _____ Surgeon's participation with the insurer?: <input type="checkbox"/> Participating <input type="checkbox"/> Non-participating</p>
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