CENTER FOR WEIGHT LOSS SURGERY
34509 9th Avenue South Suite 103 Federal Way WA 98003
Telephone: (253) 815-7774 Fax: (253) 815-7708
www.centerforweightlosssurgery.com

INFORMATION for INSURANCE VERIFICATION

This form must be filled out completely, and signed, in order to have your insurance verified. **If you are NOT having this surgery covered by insurance and are paying for it yourself please cross out the form, write "SELF PAY" and return it with the rest of the packet**. Thank you.

NAME: _______________________________________ Date of Birth: _______________ AGE: _____ SEX: _________
First MI Last

Address: ____________________________________ Home Phone: _____________________ Home Email: __________________

City: __________________________ State: _________ Zip Code: ______________ Social Security #: ___________________

Spouse/Partner's Name: _______________________________________ Your Cell phone#: _____________________________

Best way to contact you: ☐ Home Phone ☐ Email ☐ Cell phone Ok to leave phone messages? ☐ Yes ☐ No

PATIENT EMPLOYER: ________________________________ City: _________________ Occupation: ______________

Work Phone (if ok to contact): ____________________________ Work email (if ok to contact): ____________________________

INSURANCE Company: ___________________________ Subscriber Name: ____________________________________

Subscriber / ID #: _______________________ Plan: ___________ Group #: _____________ Phone: ____________________

SPOUSE/PARTNER EMPLOYER (If applicable): _____________________________ City: ______________ Date of Birth: __________

Work Phone (if ok to contact): ____________________________ Work email (if ok to contact): ____________________________

INSURANCE Company: ___________________________ Subscriber Name: ____________________________________

Subscriber / ID #: _______________________ Plan: ___________ Group #: _____________ Phone: ____________________

► If you are not married, are you covered by any other insurance policy (such as parents)? If so please indicate relationship and complete Insurance Information above.

HEALTH CARE PROVIDER:
Primary Care Physician: ________________________________ Phone: __________________________

Address: ______________________________ City__________________ State_____________ Zip Code_____________

SURGERY CHOICES: Using the numbers 1 and 2, please indicate your 1st and 2nd choices for surgery on the line next to the names of the surgeries, and check a box when appropriate.

_____ Laparoscopic Adjustable Gastric Band
_____ Roux - en -Y Laparoscopic Gastric Bypass
- ☐ Proximal
- ☐ Medial

☐ Stomaphyx

_____ Duodenal Switch
_____ Revision from prior Gastric Surgery: (Please mark your prior weight loss surgery)
- ☐ Adjustable Gastric Band
- ☐ Vertical Banded Gastroplasty (Stomach Stapling)
- ☐ Proximal Roux-en-Y Gastric Bypass
- ☐ Duodenal Switch
- ☐ Other restrictive surgery/unknown

If your 1st and 2nd choices for surgery are not approved by your employment's insurance plan, are you interested in pursuing a different surgery that is approved? ☐ Yes ☐ No

If your employment's insurance plan does not approve gastric bypass surgery of any type, are you interested in proceeding with the surgery as a cash pay patient? ☐ Yes ☐ No

Insurance Agreement:
I authorize my physician to release to my insurance company or any other third party, in order to determine my eligibility for any procedure and my liability for payment, any information including diagnosis and records of such treatment as necessary to obtain reimbursements for services rendered. I request and authorize my insurance companies to pay directly to my physician the amount due in my pending claim for surgical and/or medical care.

However, I understand that I am financially responsible for all charges regardless of insurance status.

Patient Signature: ________________________________ Date: ______________________