CENTER FOR WEIGHT LOSS SURGERY
34509 9th Avenue S, Suite 103, Federal Way, WA 98003 • 12303 NE 130th Lane, Suite 120, Kirkland, WA 98034
p: 253-815-7774 (toll free: 877-815-7774) • f: 253-815-7708 • www.c4wls.com

Information for Insurance Verification

This form must be filled out completely and signed in order to have your insurance verified. Also include a copy of the front and back of your insurance card along with this form.

► **Are you planning to have the surgery done through your insurance or opt for self-pay?** ❑ INSURANCE ❑ SELF-PAY

Name: _____ Date of Birth (DOB): _____ Gender: _____
First MI Last

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Social Security #: _____ Spouse/Partner Name: _____ Spouse/Partner DOB: _____

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): _____

Spouse/Partner Employer (if applicable): _____ City: _____

Spouse/Partner Work Phone (if ok to contact): _____ Spouse/Partner Work Email (if ok to contact): _____

► **Do you have WA Medicaid?** _ Yes _ No ► **Do you have Medicare or Medicare supplemental insurance?** Yes No

PRIMARY Insurance Company: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins. Phone: _____

Subscriber Address: _____

SECONDARY Insurance Company: _____

Subscriber Name: _____ Sub. DOB: _____

Subscriber/ID #: _____ Plan: _____

Group #: _____ Ins. Phone: _____

Subscriber Address: _____

Health Care Provider (Primary Care Physician): _____ Phone: _____ City: _____

Surgery Choices: Please indicate your first & second choice for surgery (using numbers 1 & 2), and check a box when appropriate.

_____ Sleeve Gastrectomy
_____ Duodenal Switch
_____ Roux-en-Y Gastric Bypass; ❑ Proximal ❑ Medial
_____ Adjustable Gastric Band (commonly known as Lap-Band)
_____ Revision from prior surgery: (**Please mark your prior weight loss surgery**)
- ❑ Adjustable Gastric Band
- ❑ Proximal Roux-en-Y Gastric Bypass
- ❑ Other restrictive surgery/unknown _____
- ❑ Vertical Banded Gastroplasty (Stomach Stapling)
- ❑ Duodenal Switch

_____ StomaphyX
_____ Tummy Tuck (after significant weight loss, post weight loss surgery)

_____ Office Visits
_____ Band Fills & Adjustments

If your first and second choices for surgery are not approved by your insurance plan, are you interested in pursuing a different surgery that is approved? ❑ Yes ❑ No

If your employment's insurance plan does not approve weight loss surgery of any type, are you interested in proceeding with the surgery as a self 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 payments.

Patient Signature: _____ Date: _____