GEORGETOWN
THE BARIATRIC & METABOLIC CENTER

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 or Medicaid, however it does need to be completed for Medicare Replacement, Medicare HMO and any policy that is secondary to Medicare.**

Instructions:

1. Call the customer service number located on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits.
3. Follow the script 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.
4. **Do not leave any fields blank.**
5. **Sign the form on the back. Failure to do so will result in the form being returned.**
6. Once complete, return this form, along with a copy of your insurance card(s), to our office.
7. Please also make sure that you submit your patient profile packet via fax, mail or Internet.
8. If you have more than 1 insurance policy, a form must be filled out for each. 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. If Medicaid is secondary, this form does not need to be completed.
    b. You must complete this form if you have a Medicare Replacement policy or Medicare HMO.

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	

#	Question for Representative	Answer from Representative
1	Please look in my current 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, 26, 27 & 28 then end the call.) **See explanation below
****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.**		
2	Please have the representative read the benefit or exclusion to you. Write it down word for word.	
3.	Do I have a Bariatric Lifetime Maximum?	
4	Is Georgetown Community Hospital in my network? Tax ID #: 62-1757921	

6	Is Georgetown Bariatric & Advanced Surgical Services (Eric F. Smith, D.O.) in my network? Tax ID #62-1763638	
7	What is the effective date of my policy?	
8	What is the calendar year renewal date?	
9	Am I subject to a pre-existing clause?	
10	If yes, what is the end date of the pre-existing clause?	
11	Is a referral required?	
12	What is the deductible per calendar year?	
13	How much have I met towards my deductible?	
14	What is the maximum out of pocket per calendar year?	
15	How much have I met towards my max out of pocket?	
16	Is the deductible applied to the max out of pocket?	
17	What is the co-insurance percent for my policy?	
18	What are my financial obligations to the doctor for Inpatient surgery?	
19	What are my financial obligations to the doctor for Outpatient surgery?	
20	What are my financial obligations to the hospital for Inpatient surgery?	
21	What are my financial obligations to the hospital for Outpatient surgery?	
22	What are my financial obligations to the hospital for outpatient diagnostics (routine labs and x-rays)?	
23	What is my co-pay for a primary care office visit?	
24	What is my co-pay for a specialist office visit?	
25	What is the fax number for pre-determination?	
26	Name of the representative	
27	Date you spoke to representative	
28	**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**

Disclaimer:

- The Bariatric & Metabolic Center at Georgetown 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 & Metabolic Center at GCH.

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: _____