INSURANCE QUESTIONNAIRE

Required: **Copy of insurance card**

Note: **MEDICAID PATIENTS**
Referral must be from physician listed on your medicaid card on the date of surgery

Name: ____

Date of Birth: ____________________ ______________ ________________
(month) (day) (year)

Please contact your insurance company and complete the following information:

Name of Insurance Company: ____

Insurance Company Telephone #: ( ) ________________________________

Effective Date of Policy: ____________________________Policy Renewal Date: ____________________________

Is outpatient medical treatment for morbid obesity covered? Yes _____ No _____

Is Mission Bariatric Center, 56-0532141 , BCBS Group # 018NY a participating provider? Yes _____ No _____

Inpatient and Outpatient Medical Benefits:

A) Is there a participating deductible? Yes _____ No _____

Is there a non-participating deductible? Yes _____ No _____

If yes, how much of the deductible has been met to date:________________________

B) Are there any “out of pocket” expenses? Yes _____ No_____

If yes, how much of the out of pocket has been met to date? ________________________

Is there a maximum out of pocket to be met? Yes _____ No _____How much has been met?____________

Diagnosis Code 278.01 – Morbid Obesity

If proven medically necessary, does your policy cover Gastric Bypass Surgery?

Procedure Code 43644 (laparoscopic) Yes _____ No _____

If proven medically necessary, does your policy cover Laparoscopic Adjustable Gastric Banding?

Procedure Code 43770 Yes _____ No _____

If proven medically necessary, does your policy cover Sleeve Gastrectomy?

Procedure Code 43659 (Unlisted laparoscopic procedure, stomach)Yes _____ No _____

Name of Insurance Representative you spoke with: ____________________________________

____
(date)

PAYMENT OF CO-PAYS AND DEDUCTIBLES NOT MET, WILL BE REQUIRED BY THE SURGEON OFFICE AND THE HOSPITAL PRIOR TO SURGERY.