LAP-BAND® Reimbursement Solutions Hotline

1-800-LAP-BAND Option 3 (Phone) • 1-800-711-0810 (Fax)

INSURANCE VERIFCATION REQUEST FORM

REQUIRED: **Do you have your patient's <u>written</u> 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).

Patient Information	Patient Name: ______________ M / F *(please circle)* Date of Birth: ______________ Social Security Number: ______________ Address: ______________ City, State, Zip: ______________ Phone: ______________ Fax: ______________ Height: _______ Weight: _________ BMI: ______________
Surgeon Information	Surgeon Name: Adam B. Smith or Craig Ferrara ______________ Tax ID#:______________ Specialty: Bariatric Surgery ______________ Site Name: LBS ______________ Office Contact Name: Nancy Geissler ______________ Address: 2501 Parkview Dr #560 ______________ City, State, Zip: Ft. Worth, TX 76102 ______________ Phone: 817-850-1100______________ Fax:817-870-2553 ______________ Email: nancy@fortworthlapband.com ______________ NPI # ______________
Procedure Information	Primary ICD-9 Code ___________ Secondary ICD-9 Code (if applicable)___________ CPT code 1: _43770 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: ❑ Ambulatory Surgical Center (ASC) ❑ Hosp. Outpatient ❑ Hosp. Inpatient
Co- Morbid Conditions **(Please check all that apply)**	❑ Asthma ❑ Depression ❑ GERD/Heartburn ❑ Hypercholesterolemia ❑ Hyperlipidemia ❑ Hypertension/High Blood Pressure ❑ Obstructive Sleep Apnea ❑ Osteoarthritis ❑ Pseudotumor Cerebri ❑ Swelling of the Legs (Edema) ❑ Type 2 Diabetes ❑ Urinary Stress Incontinence
Primary Insurance Information	Name of Insurance Company: ______________ Address: ______________ City, State, Zip: ______________ Phone: ______________ Fax: ______________ Policy Holder's Name:______________ Relationship to Patient: ______________ Date of Birth: ______________ Policy ID #: ______________ Group/Plan #:______________ Employer's Name: ______________ Surgeon's Provider # ***(Required for Medicare or Medicaid)***:______________ Surgeon's participation with the insurer? ❑ Participating ❑ Non-participating
Secondary Insurance Information	Name of Insurance Company: ______________ Address: ______________ City, State, Zip: ______________ Phone: ______________ Fax: ______________ Policy Holder's Name:______________ Relationship to Patient: ______________ Date of Birth: ______________ Policy ID #: ______________ Group/Plan #:______________ Employer's Name: ______________ Surgeon's Provider # ***(Required for Medicare or Medicaid)***:______________ Surgeon's participation with the insurer? ❑ Participating ❑ Non-participating