memorialbariatricsurgery CENTER
MEMORIAL HEALTH

Seminar Registration Form

Patient Information

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth _____ Social Security Number _____

Medical Information

Height: _____ Weight: _____ Gender: _____

Do you suffer from any of the following?

High Blood Pressure ☐Yes ☐No Type 2 Diabetes ☐Yes ☐No

Sleep Apnea ☐Yes ☐No Heart Disease ☐Yes ☐No

Insurance Information

PRIMARY INSURANCE		***SECONDARY INSURANCE***	
Employer:		Employer:	
Insurance Company:		Insurance Company:	
Insured Date of Birth:		Insured Date of Birth:	
Policy Number:		Policy Number:	
Group Number:		Group Number:	
Phone Number:		Phone Number:	

Primary Care Physician

Primary Care Physician: _____

Did he/she discuss bariatric (weight loss) surgery with you? ☐YES ☐NO

How did you hear about bariatric surgery at Memorial Hospital?

☐ Newspaper _____ ☐Bariatric Center at Memorial Hospital

☐Doctor _____ ☐ Billboard

☐ Friend _____ ☐Radio Advertisement

☐Internet ☐TV Advertisement

☐Mailer/Post card ☐Other_____

I certify and attest that the above information provided is true and correct and that the person named above has attended the Bariatric Informational Seminar and received the "Memorial Bariatric Surgical Procedure Guide" that includes explanation of all available surgical options and expected outcomes of each procedure with clear explanation of the goals, risks, benefits, and alternatives of each procedure.

_____ _____

Print Name Today's Date

_____

Signature

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FOR OFFICE USE ONLY				
Is this a Medicare Replacement Policy?	☐YES	☐NO	☐ Barilink	☐ Call PT
Treatment of morbid obesity (278.01) covered?	☐YES	☐NO	☐ Insurance	☐ Notify Surgeon
Which procedures are covered?				
☐43644 – Short Limb Bypass ☐43770 – Adjustable Band				
☐43645 – Long Limb Bypass ☐43775 – Sleeve Gastrectomy			Notes	
Only one per lifetime?	☐YES	☐NO		
Special distinction for the facility required?	☐YES	☐NO		
Special distinction for the physician required?	☐YES	☐NO		
Policy available online?	☐YES	☐NO		

Requirements for Medical Necessity and/or Repeat Surgery:

General Benefits

Ded _____ Co Insurance _____

Co Pay _____ Stop Loss _____ - Ded. Incl.? ☐YES ☐NO

Out of Network Benefits?	☐YES	☐NO
Benefits Bariatric Specific	☐YES	☐NO

Date	
Spoke To	
Reference Number	
Completed By	