THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

BARIATRIC SURGERY PROGRAM APPLICATION

Instructions: 1) Type directly into form – complete all pages. 2) Save form and print a copy for your records. 3) Email saved form to: ObesitySurgery@osumc.edu or mail/drop off a copy to Martha Morehouse Medical Plaza, 2050 Kenny Rd, 2nd Floor Pavilion, Suite 2500, Columbus OH, 43221.

Date:	

SELF

Last Name:		First:		MI:		Maiden:			
Address:									
City:		State:		Zip:					
Home #:		Cell #:		Work #:					
Date of Birth:		SSN#:							
Gender:	☐ Male	☐ Female							
Marital Status:	☐ Married	☐ Divorced	☐ Widowed	☐ Separated	☐ Never Married				
Race:	☐ White	☐ Hispanic	☐ Asian	☐ Native American / Alaskan Native					
	☐ African American		☐ Other:						
Employer :									

YOUR PRIMARY CARE PROVIDER

Physician:					
Address:					
City:		State:		Zip:	
Phone:		Fax:			

PRIMARY INSURANCE INFORMATION

Primary Insurance Co:					
Address:					
City:		State:		Zip:	
Policy Holder's Name:					
Relationship to Patient:					
Policy #:		Group / Plan #:			
Customer Service Phone:					
Provider Inquire / Pre-Certification Phone:					
Contact Person:					
Is Gastric Bypass and/or Lap-Bank for "Morbid Obesity" a covered benefit?			☐ Yes	☐ No	
If you have EVER had Bariatric surgery: Is REVISION SURGERY a covered benefit:			☐ Yes	☐ No	

SECONDARY INSURANCE INFORMATION

Secondary Insurance Co:					
Address:					
City:		State:		Zip:	
Policy Holder's Name:					
Relationship to Patient:					
Policy #:		Group / Plan #:			
Customer Service Phone:					
Provider Inquire / Pre-Certification Phone:					
Contact Person:					
Is Gastric Bypass and/or Lap-Bank for "Morbid Obesity" a covered benefit?			☐ Yes	☐ No	
If you have EVER had Bariatric surgery: Is REVISION SURGERY a covered benefit:			☐ Yes	☐ No	

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Surgeon of Preference:	☐ Dr. Needleman	☐ Dr. Noria
Are you utilizing the SELF-PAY option?	☐ Yes	☐ No

(If YES, please complete the Psychological Evaluation FIRST with Dr. Kramer: 614-366-6675)

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity.

I understand that I am financially responsible for any balance not covered by the insurance carrier(s).

I also request that payment of benefits from my policy _____ (Medigap/other) be paid directly to the billing entity until otherwise notified.

Signature: _____

Signature of Parent (if minor): _____

MEDICAL HISTORY

TOBACCO PRODUCTS:

Do you smoke?	☐ Yes	☐ No		
If NO, do you use any tobacco products?	☐ Yes	☐ No		
Have you EVER used tobacco products?	☐ Yes	☐ No		
If YES, what kind?		How often?		
What year did you start?		Quit date:		

ALCOHOL CONSUMPTION:

How much of the following do you drink per week?			
Mixed Drinks (1oz/drink)			
Beer (12oz)			
Wine (6oz/glass)			
Do you have a history of alcohol abuse?	☐ Yes	☐ No	
Have you ever felt or been told that you have a drinking problem?	☐ Yes	☐ No	

ALLERGIES:

Are you allergic to any drug, food or substance?	☐ Yes	☐ No		
If YES, list each allergy and reaction	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	
	Allergy:		Reaction:	

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MEDICATION LIST:

Medication Name	Dosage	Frequency	Why do you take it?

MOBILITY / ACTIVITY:

Do you use a wheelchair:	☐ Yes	☐ No	If YES, how many hours per day?	
How far do you walk in a normal day?				
How many steps can you climb?				
How many steps do you climb daily?				

DIET HISTORY:

Current Weight:		Weight at 18 Years of Age:	
Height:		Goal (Desired) Weight:	

1. Record ALL weight loss attempts, especially professionally supervised (physician, and/or registered dietitian) programs.
2. Start with your first diet and proceed until the most recent one.
3. If you were on weight-loss medications (e.g. Adipex, Redux, Meridia, Xenical), what type of "food plan" were you following (e.g. 1200-calorie, low-fat, low-carbohydrate, etc.) in addition to taking the drug?

Year	Age at Start of Diet	Length of Time on Diet	Weight at Start of Diet	Weight Lost on Diet	Type of Diet	Indicate if Doctor or Dietitian Supervised

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ILLNESSES / MEDICAL CONDITIONS:
Please mark all illnesses or medical conditions that you and/or your blood relatives have ever had:

	You	Mother	Father	Brother(s)	Sister(s)
Angina / Chest Pain	☐	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐
PTCA (Balloon Angioplasty / Stent)	☐	☐	☐	☐	☐
Coronary Bypass Surgery	☐	☐	☐	☐	☐
Stroke / TIA (Mini Stroke)	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Sugar / Diabetes	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Peripheral Vascular Disease (PVD)	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Colon / Rectum Cancer	☐	☐	☐	☐	☐
Lung Cancer	☐	☐	☐	☐	☐
Prostate / Testicular Cancer	☐	☐	☐	☐	☐
Uterine / Ovarian Cancer	☐	☐	☐	☐	☐
Other Cancer (list):	☐	☐	☐	☐	☐
Depression / Anxiety	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐
Bleeding issues	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Gallbladder trouble	☐	☐	☐	☐	☐
Heartburn / Indigestion	☐	☐	☐	☐	☐
Stomach Ulcers	☐	☐	☐	☐	☐
Frequent Constipation	☐	☐	☐	☐	☐
Frequent Diarrhea	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐
Hernia	☐	☐	☐	☐	☐
Bowel Incontinence	☐	☐	☐	☐	☐
Frequent Headaches	☐	☐	☐	☐	☐
Clotting Problems	☐	☐	☐	☐	☐
Fatty Liver Disease	☐	☐	☐	☐	☐
Hepatitis B or C	☐	☐	☐	☐	☐
HIV	☐	☐	☐	☐	☐
LUPUS	☐	☐	☐	☐	☐
Polycystic Ovarian Syndrome	☐	☐	☐	☐	☐

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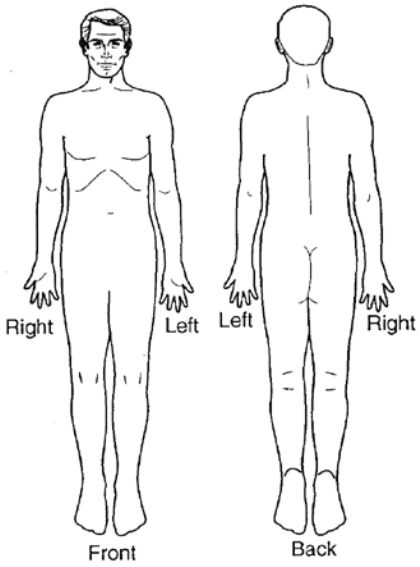
I agree to a blood transfusion, if needed. (please indicate your choice) ☐ Yes ☐ No

(Please note: refusal of medically necessary blood products will affect your ability to have weight loss surgery at The Ohio State University Wexner Medical Center.)

Use C-PAP or BI-PAP?	☐ Yes	☐ No
Use OXYGEN?	☐ Yes	☐ No
How many liters?		
Hours per day?		

SURGERIES:

Date:	Type of Surgery:	Below, please indicate the location of any surgical incisions (scars from surgeries) that you have.
		

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VELANOVICH GERD SYMPTOM SCALE

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

GERD Medication: (reflux / heartburn) _____ Dose: _____

The gastroesophageal health related quality of life instrument:

Scale	Description
0 =	No symptoms
1 =	Symptoms noticeable, but not bothersome
2 =	Symptoms noticeable and bothersome, but not every day
3 =	Symptoms bothersome every day
4 =	Symptoms affect daily activities
5 =	Symptoms are incapacitating – unable to do daily activities

Questions about symptoms while taking medications for GERD (reflux/heartburn):
Check one box for each question using number scale explained above.

	0	1	2	3	4	5
1. How bad is your heartburn?	☐	☐	☐	☐	☐	☐
2. Do you have heartburn when lying down?	☐	☐	☐	☐	☐	☐
3. Do you have heartburn when standing up?	☐	☐	☐	☐	☐	☐
4. Do you have heartburn after meals?	☐	☐	☐	☐	☐	☐
5. Does heartburn change your diet?	☐	☐	☐	☐	☐	☐
6. Does heartburn wake you from sleep?	☐	☐	☐	☐	☐	☐
7. Do you have difficulty swallowing?	☐	☐	☐	☐	☐	☐
8. Do you have pain with swallowing?	☐	☐	☐	☐	☐	☐
9. Do you have gassy or bloating feelings?	☐	☐	☐	☐	☐	☐
10. If you take medications, does this affect your daily life?	☐	☐	☐	☐	☐	☐
11. How satisfied are you with your present condition?	☐ Satisfied		☐ Neutral		☐ Dissatisfied	

Total = _____ + _____

Reference: Velanovich V, Vallance SR, Gusz JR, Tapia FV, Harkabus MA: Quality of life scale for gastroesophageal reflux disease. J Am Coll Surg 183:217-224, 1996.

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ANVARI GERD SYMPTOM SCALE

MR#: _____

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

GERD Medication: (reflux / heartburn) _____ Dose: _____

Please answer the following questions by checking the box that best describes your symptoms while taking medication for GERD (reflux/heartburn).

	Not at all	Mild	Moderate	Severe
1. How much does heartburn bother you?	☐	☐	☐	☐
2. How much does regurgitation bother you?	☐	☐	☐	☐
3. How much does stomach or chest pain bother you?	☐	☐	☐	☐
4. How much does feeling overly full bother you?	☐	☐	☐	☐
5. How much does difficulty swallowing bother you?	☐	☐	☐	☐
6. How much does coughing bother you?	☐	☐	☐	☐

	No Symptoms	Symptoms occur once a month	Symptoms occur once a week	Symptoms occur 2-4 times a week	Symptoms occur daily
1. How often do you have heartburn?	☐	☐	☐	☐	☐
2. How often do you have regurgitation?	☐	☐	☐	☐	☐
3. How often do you have stomach or chest pain?	☐	☐	☐	☐	☐
4. How often do you feel overly full?	☐	☐	☐	☐	☐
5. How often do you have difficulty swallowing?	☐	☐	☐	☐	☐
6. How often do you have a cough?	☐	☐	☐	☐	☐

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INSURANCE DISCLAIMER FORM

Many insurance companies have specific requirements that must be met before surgery is approved. The form below must be completed for all insurance companies except Medicare. It will help you to know and understand your benefits.

Instructions:

1. Call the customer service number on your insurance card and speak to a customer service representative.
2. Tell the representative that you would like to check policy benefits for weight loss surgery for morbid obesity.
3. Read the questions word for word to get the most accurate information. Please complete all questions and sign the form.
4. Fill out a form for each insurance company if you have more than one. Make as many copies as needed.

Disclaimer:

- The Ohio State University Wexner Medical Center Bariatric Surgery Program is NOT responsible for incorrect information provided by the insurance company.
- Completion of this form does not mean that you are approved for weight loss surgery and does not guarantee payment for services. You will be responsible for any charges that your insurance does not cover.

---------- *Type in the information below BEFORE you call the insurance company.* ----------

Patient's Name:	
Patient's Date of Birth:	
Insurance Provider:	
ID Number:	
Group Number:	
Subscriber Name:	
Subscriber's Employer:	
Subscriber's Date of Birth:	
Insurance Company Name:	
Member Customer Service Number:	
Date Contacted:	
Name of Customer Service Representative:	

1. **"Hello, my name is: _____**
   I would like to learn about my plan benefits with regard to morbid obesity surgeries, including gastric lap band, gastric sleeve and gastric bypass surgery. Does my policy cover these services or is there an exclusion in my contract?"
   (If there is an exclusion, the rest of the questions do not apply. Stop here!)

2. If you are applying for a revision surgery, ask:
   "Do I have benefits in my policy for a revision of previous weight loss surgery?"
   ☐ Yes ☐ No
   If yes, please verify specific requirements: _____

3. **"Is The Ohio State University Wexner Medical Center in my network?"**
   ☐ Yes ☐ No

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Insurance Disclaimer Form (continued)

4. **"Are these Surgeons in my Network?"**
   Dr. Bradley Needleman: ☐ Yes ☐ No
   Dr. Sabrena Noria: ☐ Yes ☐ No

5. **"Does my policy cover services for associated surgery clearances such as cardiac, pulmonary, psychological evaluations and pre-admission testing?"**
   ☐ Yes ☐ No

6. If benefits are allowed, ask the following questions:
   "What is the minimum BMI?" _____
   "If my BMI is Below 40, are there any co-morbidities that I must have to qualify for insurance approval?" (Please list)
   _____

7. **"At what level does my policy pay for the following services."** (For example 80%, 100%)

% of Payment	CPT Code	Diagnosis Code
	43846 Open Revision	278.01
	43770 Gastric Lapband	278.01
	43775 Gastric Sleeve	278.01
	43644 Gastric Bypass	278.01

8. **"How much is my deductible?"** _____

9. **"What is my office visit co-payment?"** _____

10. **"What records are needed for approval?"** Fill in information given in these areas:
    Diet history for _____ months, within in the past _____ months.
    Exercise history for _____ months, within in the past _____ months.
    Weight history for _____ months, within in the past _____ months.

11. **"Do I need to complete a medical weight management program before surgery is approved?"**
    ☐ Yes ☐ No
    If yes, ask "how long? ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

12. **"Does this program need to be supervised by a physician?"**
    ☐ Yes ☐ No
    - If yes, please plan to make monthly appointments with your family doctor.
    - Ask your doctor to include height, weight and recommendations for a diet and exercise plan in each visit note.
    - Please note: Based on your clinical evaluations, an education program may need to be completed in addition to any insurance requirements.

Patient Signature: _____

Date: _____