SIBLEY MEMORIAL HOSPITAL
JOHNS HOPKINS MEDICINE

Insurance Verification for Bariatric Surgery

Form Must be completed prior to scheduling an Initial Surgical Consultation

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Name of Representative: _____ **Reference No.:** _____

Please contact the customer service number on your insurance card to verify benefits or contact your Employer Benefits Dept. to verify your current insurance benefits.

Morbid Obesity / Bariatric Surgery Coverage

Does my policy have coverage for Gastric Bypass / Morbid Obesity? Yes / No

Procedure code: 43644 or Diagnosis Code E66.01

Am I required to have participated in a structured weight management program? Yes / No

How many months are required? 90days / 180days / Other: _____

Is a Bariatric Center of Excellence or COE facility required for surgery? Yes / No

***If YES**, please contact the office to discuss options.*

Is Sibley Memorial Hospital (NPI-1366492977) in my preferred network? Yes / No

Is Katherine Lamond, M.D. (NPI-1902010184) in my preferred network? Yes / No

General Policy Information

What is my annual deductible? $_____ Have I met the deductible amount this year? Yes / No

What date does my deductible renew: _____ What is my office visit co-pay? $_____

Do I have a surgery co-pay amount? _____ What % of surgery is covered? %_____

What is the annual out of pocket maximum: $ _____

I acknowledge that this information is true and correct to the best of my knowledge. Any changes to the insurance policy may result in a change of coverage, reimbursement, and / or exclusion of Bariatric benefits.

It is the responsibility of the patient to re-verify coverage as necessary.

PRINT NAME **SIGNATURE** **DATE**