INSURANCE VERIFICATION REQUEST FORM

Patient Information	Patient Name: _____ ☐M ☐ F *(please select)* Date of Birth: _____ Social Security Number: _____ Address: _____ City, State, Zip:_____ Phone:_____ Fax:_____ Height: _____ Weight: _____ BMI: _____
Surgeon Information	Surgeon Name: Adam B. Smith, D.O. or Craig A. Ferrara, D.O. Date of Patient Consultation: _____
Procedure Information	Procedure (circle) Lap Band, Sleeve, Hiatal Hernia, LB Adj. or other_____ Insurance verification is to verify coverage and benefits, not a pre-authorization for surgery.
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 # (required):_____ Group/Plan # (required):_____ Employer's Name (required):_____ 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 #: _____ Group/Plan #: _____ Employer's Name: _____ Surgeon's participation with the insurer? ❑ Participating ❑ Non-participating

I give my consent for the above information to be used to verify benefits and bariatric coverage

Signature Date

Fort Worth Lap Band

2501 Parkview Dr., Suite 560, Fort Worth, Texas 76102

Tel 817-850-1100 Fax 817-870-2553