YOU WILL NEED TO CALL YOUR INSURANCE COMPANY TO ASK THE FOLLOWING QUESTIONS BEFORE YOUR FIRST APPOINTMENT.

**PROCEDURE CODES:**
- **LAP ROUX-EN-Y GASTRIC BYPASS:** CPT CODE: 43644
- **LAP ADJUSTABLE BANDING:** CPT CODE: 43770
- **LAP SLEEVE GASTRECTOMY:** CPT CODE: 43775

**DIAGNOSIS CODE:**
- **MORBID OBESITY:** ICD-9 code: 278.01

1. **REPRESENTATIVE AT INSURANCE COMPANY (NAME):**

2. **DO I HAVE BENEFIT COVERAGE FOR MEDICALLY NECESSARY WEIGHT LOSS SURGERY FOR MORBID OBESITY FROM MY INSURANCE COMPANY?**
   - Yes
   - No

3. **ARE ABOVE PROCEDURES (CODES LISTED ABOVE) COVERED IF I HAVE SURGERY AT THE UNIVERSITY OF MICHIGAN?**
   - Yes
   - No

4. **WHAT IS MY INSURANCE BENEFIT OR EXCLUSION?**

5. **DOES MY WEIGHT LOSS SURGERY BENEFIT REQUIRE A MEDICALLY SUPERVISED WEIGHT LOSS TRIAL PROGRAM?**
   - Yes
   - Length of Program: __________
   - No

6. **IS A PRIMARY CARE PHYSICIAN REQUIRED TO COMPLETE THE WEIGHT LOSS DOCUMENTATION OR CAN A SPECIALTY DOCTOR RECOMMEND AND FOLLOW THE WEIGHT LOSS TRIAL PROGRAM?**

7. **WHAT IS MY CO-PAY FOR A PRIMARY CARE OFFICE VISIT?**
   - $_________

8. **WHAT IS MY CO-PAY FOR A SPECIALIST CARE OFFICE VISIT (EXAMPLE: LAP BAND ADJUSTMENT)?**
   - $__________ *(ADJUSTMENTS FOR THE LAP BAND: CPT CODE: HCPCS S2083)*

9. **HOW MANY NUTRITION APPOINTMENTS WILL BE COVERED WITH THE DIAGNOSIS OF MORBID OBESITY?**
   - Individual
   - Group

10. **WHEN IS THE EFFECTIVE DATE OF THE POLICY?**
    - __________ (MM/DD/YYYY)

11. **WHEN IS THE RENEWAL DATE?**
    - __________ (MM/YYYY)

12. **DO I HAVE A PRE-EXISTING CLAUSE?**
    - Yes
    - No

13. **WHEN IS THE END DATE OF THE PRE-EXISTING CLAUSE?**
    - __________ (MM/DD/YYYY)

14. **IS A REFERRAL REQUIRED FROM MY INSURANCE COMPANY?**
    - Yes
    - No

15. **WHAT IS MY DEDUCTIBLE PER CALENDAR YEAR?**
    - $__________
    - How much has been met? $__________
    - How much paid to date? $__________

16. **WHAT IS THE MAXIMUM OUT-OF-POCKET COST PER CALENDAR YEAR?**
    - $__________

17. **WHAT IS THE CO-INSURANCE FOR MY POLICY?**

18. **WHAT IS MY IN-PATIENT SURGICAL CO-PAY TO THE DOCTOR?**
    - $__________

19. **WHAT IS MY OUT-PATIENT SURGICAL CO-PAY TO THE DOCTOR?**
    - $__________

20. **WHAT IS MY IN-PATIENT SURGICAL CO-PAY TO THE HOSPITAL?**
    - $__________

21. **WHAT IS MY OUT-PATIENT SURGICAL CO-PAY TO THE HOSPITAL?**
    - $__________

**PATIENT’S EMPLOYER:**

**OCCUPATION OR TYPE OF WORK PERFORMED:**