

Bariatric Surgery Program
25 Courtenay Drive
Ashley River Tower
MSC 290
Charleston, SC 29425-2900
(843) 876-4264 phone
(843) 876-4201 fax

www.muschealth.org/weight-loss-surgery

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To our patients considering weight loss surgery:

Thank you for your interest in the Charleston MUSC Metabolic & Bariatric Surgery Program. Congratulations on your decision in pursuing a lasting and effective treatment for your obesity, together with our team.

Before you fully commit to weight loss surgery, we strongly suggest that you contact your insurance carrier to verify that weight loss surgery is a covered benefit under your policy. Some policies exclude all types of weight loss surgery. It can be extremely disappointing to find out that you do not have coverage after going through the evaluation process. So we encourage you to find out prior to submitting your application. **We have included a sample of the questions for you to call your insurance company to ask first.**

If your insurance carrier does not cover the procedure, please call us at 843-876-4264 to discuss self-pay details.

Enclosed in this packet is an outline of the steps required to have surgery (keep this for your planning purposes).

Please complete and return:

Patient Information Form (page 3)

Nutrition Questionnaire (page 4)

Medical History Questionnaire (pages 5-7)

Return by mail, email, or fax:

Mail: MUSC Bariatric Surgery Program
25 Courtenay Drive, Ashley River Tower
MSC 290
Charleston, SC 29425 - 2900

Email: wls@musc.edu

Fax: (843) 876-4201

When we receive your **Patient Information Form, Nutrition Questionnaire,** and **Medical History Forms** we will be in touch with you to discuss next steps.

Please visit our website for more information and resources www.muschealth.org/weight-loss-surgery

Yours sincerely,

The MUSC Bariatric Surgery Team

Rana Pullatt, MD, Professor, Department of Surgery, Diplomate in Obesity Medicine, Medical Director, Clinical Director Bariatric & Robotic Surgery, Director Bariatric Surgery VISN-7

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Mary Kate Bryant, MD, Professor of Surgery
Aaron Leshner, MD, Associate Professor of Surgery and Pediatrics

Call your Insurance Company to Verify Benefits for Bariatric Surgery

- Call the benefits coordinator at your human resource office and/or call the customer service line listed on your insurance card
- Once you are connected to a representative, ask the following questions to determine your policy benefits
- Please note that even if the representative states that bariatric surgery is a covered benefit, this is not a guarantee of coverage or payment

Consider this list to help you ask all the questions and to document the answers received:

Telephone number and extension called:	Name of Insurance Company/Your employer: Phone #/Extension: Person you spoke with and a reference number for the call:
“I am inquiring about my policy benefits regarding the surgical treatment of morbid obesity.	Is surgery for morbid obesity a covered benefit?” Yes or No: Do I have to go to a center of excellence or center with a specific designation and if so, Is MUSC one? Yes or No:
Which CPT codes/surgical procedures are covered?	43775 – sleeve gastrectomy 43644 – gastric bypass 43845 – duodenal switch Other:
Is MUSC in-network with this insurance plan?	Yes or No:
Do you have a policy on surgery for morbid obesity that I can obtain?	Ask to have it sent/mailed to you or direct you to webpage
Ask what other requirements the insurance company has for you to complete in order to approve surgery.	Medically supervised weight loss attempt? Yes or No? How many months? (3-6?): How long ago must these monthly visits be? <i>Typically, within past 6-24 months:</i> Who must the visit be with? <i>Typically, MD or RD supervised by MD:</i> Weight history of having obesity for certain # of years? Does my Primary Care Provider have to refer me or provide a recommendation to have surgery? Yes or No? Do I need other clearances? <i>Some require heart and lung clearances, checking TSH, or negative H Pylori test:</i> Weight or BMI requirement? Yes or No? <i>Usually it is BMI>40 kg/m2, or BMI>35 kg/m2 with associated medical problems.</i> Any specific health conditions (comorbidities) required if BMI is between 35-40?



Metabolic & Bariatric Surgery Program

Patient Information Packet





ASCREENCRIT
Bariatric Surgery Program
Initial Patient Application

Form Origination Date: 5/2016
 Version: 1

Version Date: (5/2016)

Patient Name _____
 MRN _____
PATIENT IDENTIFICATION LABEL

MUSC Bariatric Surgery Program Patient Information Form (Complete & Return)

Name _____ Birth date ___ / ___ / ___ Sex ___ Marital Status _____
 SS# _____ Address _____
 City _____ County _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Ethnicity _____ Email address _____

Occupation _____
 Employer's Name & Address _____

Primary Care Provider (PCP) _____
 Address of PCP _____ PCP phone _____
 Referring Physician _____
 Address of Referring _____ Referring phone _____

Emergency Contact Name _____ Relationship _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information: (Give as much information from your card, and enclose a copy if possible)

Name of Primary Insurance _____	Name of Secondary Insurance _____
Address _____	Address _____
Customer Service Phone # _____	Customer Service Phone # _____
Prior Authorization Phone # _____	Prior Authorization Phone # _____
Policy or ID # _____	Policy or ID # _____
Group or Plan# _____	Group or Plan# _____
Subscribers Name on Card _____	Subscribers Name on Card _____
Relationship to Patient _____	Relationship to Patient _____
Subscribers Employer _____	Subscribers Employer _____

Have you verified that your insurance company has benefits for bariatric surgery? Yes No

How did you hear about us?

MUSCHealth Website Internet – other Facebook Newspaper Magazine
 Television Physician: Name: _____ Friend: Name: _____

Indicate the Procedure you are interested in:

Gastric Bypass Sleeve Gastrectomy Other: _____

Can the patient read or write? Yes No Form completed by: Patient

MUSC Bariatric Surgery Program Nutrition Questionnaire (Please Complete & Return)

Personal Information:

Name: _____

Date of Birth: _____

Email: _____

Height (inches): _____

Weight (pounds): _____

Previous Attempts at Weight Loss Efforts (Past 5 Years only):

List Programs (like Weight Watchers, Metabolic Medical Center), Diets (like Atkins, South Beach), Medications (like Phentermines, Belviq), Over the Counter products (like Alli, Metabolife), physician or dietitian supervised weight loss attempts, or weight loss surgery.

Name of weight loss program, diet, medication, past history of bariatric surgery	Date/year you started	How long on it (days, weeks, months, or years)	How many pounds did you lose

Daily Routine:

What do you do for work? _____ What are your typical work hours? _____

Who else lives in the home with you? _____

Who does the food shopping and preparation? _____

Do you plan meals in advance? _____ Do you shop from a list? _____

Where do you typically eat your meals (table, couch, bed, kitchen)? _____

Do you have any food allergies or intolerances? _____

Are you taking vitamin and mineral supplements? (please list) _____

Weight Loss Surgery Expectations:

Which type of weight loss surgery are you interested in? _____

How much weight do you hope to lose with surgery? _____

In what time frame do you expect to lose this weight? _____

Do you have any non-scale goals or things you are looking forward to with weight loss? _____

What do you feel is your biggest challenge when it comes to changing your eating habits? _____

Metabolic & Bariatric Surgery Program

New Patient Medical Questionnaire

PLEASE COMPLETE ENTIRE FORM

PATIENT NAME: _____

Person completing form: PATIENT OTHER (Name/Relation): _____

PRIMARY CARE PROVIDER: If you do not have a PCP, you can call (843) 792-7000 to establish care with an MUSC PCP

Name	Address	Phone

CURRENT HEIGHT (inches): _____ **WEIGHT (pounds):** _____

PAST MEDICAL HISTORY	Additional Questions	YES	NO or NA
Diabetes	Type 1 Type 2 taking insulin		
Thyroid Problems			
High Blood Pressure			
High Cholesterol (or lipids)			
Congestive Heart Failure (CHF)			
Heart Attack or Cardiac Stent			
Sleep Apnea (OSA)	CPAP BiPAP		
Oxygen Dependent			
Asthma			
Emphysema (or COPD)			
Pulmonary Embolus (PE) or Deep Vein Thrombosis (DVT)			
IVC Filter for blood clot (Therapeutic Anticoagulation)			
Arthritis	Osteo Rheumatoid		
Gout			
Pain in joints, back, hip, or knees	Joint Back Hip Knee		
Scleroderma			
Connective Tissue Disease			
Irritable bowel syndrome (IBS)			
Diverticulosis/diverticulitis			
Crohns' Disease or Ulcerative Colitis			
GERD (Reflux or heartburn)			
Constipation (Chronic)			
Chronic Steroid/Immunosuppressant use			
Polycystic Ovarian Syndrome (PCOS)			
Kidney disease	on Dialysis		
Urinary Stress Incontinence			
Cancer; Type:	Chemotherapy Radiation		
Mental health history:			

Metabolic & Bariatric Surgery Program New Patient Medical Questionnaire

PLEASE COMPLETE ENTIRE FORM

PAST SURGICAL HISTORY

PROCEDURE/OPERATION (Laparoscopic or Open)	DATE	SURGEON	HOSPITAL

Have you ever had bariatric or weight loss surgery? List type, date, surgeon, hospital:

MEDICATIONS:

MEDICATION NAME	DOSE (mg, mcg, etc)	HOW OFTEN?	REASON FOR MED
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Do you have any allergies? What is your reaction? _____

Metabolic & Bariatric Surgery Program New Patient Medical Questionnaire

PLEASE COMPLETE ENTIRE FORM

ADDITIONAL QUESTIONS

Do you smoke cigarettes, cigars, or use any nicotine products?	<input type="checkbox"/> Never	<input type="checkbox"/> Yes, current	<input type="checkbox"/> Former	Year Started:	Year Quit:
Do you use smokeless tobacco, such as E-cig/vaping, dip, or chewing tobacco?	<input type="checkbox"/> Never	<input type="checkbox"/> Yes, current	<input type="checkbox"/> Former	_____	_____
Do you drink alcohol?	<input type="checkbox"/> Never	<input type="checkbox"/> Yes, current	<input type="checkbox"/> Former	_____	_____
Do you use recreational drugs?	<input type="checkbox"/> Never	<input type="checkbox"/> Yes, current	<input type="checkbox"/> Former	_____	_____
List type of recreational drugs used:					
Do you use birth control?	<input type="checkbox"/> Not applicable	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type: _____	
Do you use assistive devices for walking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Type: _____		
Do you rely on others for transportation?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who: _____		
Do you have additional support from at least 2 adults after you have weight loss surgery?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Who: _____		
Do you have financial concerns?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<i>You will be required to take vitamins/supplements for life after weight loss surgery. These could cost you approximately \$20-35/month</i>		

If you have any questions while filling out this form, please contact us at 843-792-3046