THE UNIVERSITY OF KANSAS HEALTH SYSTEM
St. Francis Campus

BARIATRIC PATIENT INFORMATION PACKET

The staff at The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery recognizes the very difficult issues associated with both the treatment of obesity and the disease itself. Obtaining surgical clearance and insurance approval can be a time-consuming and difficult process, as well.

In order to facilitate the pre-operative education process, we ask that you view an online information seminar. After you have completed the seminar, we begin the process of gathering information necessary to determine if you are an appropriate candidate for bariatric surgery. The forms included in this packet assist us in preparing a plan of care designed specifically for you based on the procedure you are interested in, your current health, previous abdominal surgeries, and your insurance benefits. **We ask that you complete this packet in its entirety. Failure to do so will result in the packet being returned to you.** Please note on the application which procedure(s) you are interested in: Sleeve Gastrectomy (Sleeve); Roux-en-Y Gastric Bypass (RNYGB); or the Biliopancreatic Diversion with Duodenal Switch (BPD/DS.)

Once you have completed this information packet you may return it via mail, email, fax, or hand-deliver to our office Monday through Friday, 8:00am – 5:00pm. **Please include a photocopy of both the front and back of your insurance / ID card** (DO NOT SEND YOUR INSURANCE CARD – YOU MAY NEED IT!) and a referral from your Primary Care Physician **IF your insurance requires a referral from your Primary Care Physician to see a Specialist**. Tricare applicants should also photocopy their referral notice and send the copy with your application. We can make copies at the office if you deliver your application in person.

Once we receive your application, we will review the information and we will contact you with a consultation date.

Most health insurance companies offer policies that provide coverage for the surgical treatment of obesity. **Please understand that it is your responsibility to know what your policy will and will not cover in regards to bariatric surgery.** You may obtain this information by calling the Customer Service phone number listed on the back of your insurance card(s).

Please understand that until all documentation has been received and reviewed thoroughly by our surgeons, it is not possible to determine if you are an appropriate candidate for weight loss surgery. **There is no guarantee, even after you have completed all of the requirements set forth herein, that we will proceed with surgery. It may be determined that you are not an appropriate candidate and / or you do not meet medical necessity to proceed with weight loss surgery.**

We reserve the right to let you know that you are not a candidate for our surgical weight loss program.

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Patient Responsibilities:

1) Please complete the enclosed health questionnaire in its entirety. **Failure to do so will result in the packet being returned to you.** Please return this packet via mail, email, fax or hand-deliver to our office Monday through Friday, 8:00am to 5:00pm. **Please include a photocopy of both the front AND back of your insurance card** (or you may bring the card by our office to be copied.) Please obtain a referral from your physician (it is your responsibility to obtain a referral **IF** your insurance requires a referral to see a **Specialist)** and send a copy of the referral with your application.

2) **Please call your insurance company to determine if you have benefits for bariatric surgery**. It is not required but would be helpful if you can obtain the following information while you are verifying benefits: a) Phone number / address / fax number for predetermination; and b) Requirements for approval / predetermination for bariatric surgery (i.e. some companies require a copy of the psychological evaluation, documentation of a medically-supervised diet to include monthly weigh-ins, an evaluation by a registered dietician, etc.)

3) We require a visit with our Registered Dietitian prior to submitting to insurance. This visit can be either in-person or virtual. The Registered Dietitian is located in the same office as the surgeon.

4) We require psychological clearance for bariatric surgery prior to scheduling surgery. **It is your responsibility to obtain psychological clearance.** This does not need to be done prior to the initial consultation, but we will not submit for insurance authorization, nor will surgery be scheduled, until we have received psychological clearance. This needs to be a psychological evaluation / pre-operative clearance for bariatric surgery, performed by a psychologist / psychiatrist / mental health provider. (Please note: Some insurance companies have rigid requirements regarding the type of provider completing the psychological evaluation. **Please be sure to verify this requirement with your insurance company prior to completing this step!)** If you are already established with a provider they may be able to perform this evaluation / clearance for you. If not, we do have a list of providers available. Please note we do have guidelines that must be reviewed during the evaluation process that we can either fax or email to a provider. **Please contact our office with the name and fax number or email address of your psychological provider so that we may provide these guidelines.**

5) Please note that once your surgery has been scheduled, we will contact your insurance company to confirm what your estimated deductible / co-insurance for bariatric surgery will be (the estimated amount due to The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery) which will need to be paid in full prior to your surgery date, or surgery will be postponed until this has been paid in full. (You will be refunded for any overpayment or billed for any underpayment of your deductible / co-insurance due to The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery once insurance has processed the claims.) **The facility (The University of Kansas Health System St. Francis Campus) will also verify your benefits prior to surgery and will contact you regarding your estimated financial responsibility to the facility. (Please note there may be additional fees related to anesthesia, radiology and pathology that you will be responsible for.)**

5) **Our office will contact you regarding your consultation once we have received and reviewed your health questionnaire**. If you have not heard from us **within two weeks** after you have submitted your questionnaire, please contact us.

Thank you for your interest in our program. We sincerely hope we are able to assist you as you explore surgical options for a healthier life. If you have questions, please call or email Rachelle Garland, RN, BSN, Bariatric Nurse (rachelle.garland@kutopeka.com) at 785-295-5429 or Brenda Holliday-Stanton, MBS Coordinator (brenda.holliday-stanton@kutopeka.com) at 785-270-7320.

THE UNIVERSITY OF KANSAS HEALTH SYSTEM
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Bariatric Program Requirements

1. Patients must review our online bariatric surgery seminar which is conveniently available 24/7. To access the seminar please go to: https://kutopeka.com/services/weight-loss/weight-loss-surgery-seminar.

   The online seminar is the first step to enter our program. We will not be able to schedule a consultation until you have viewed the online seminar and completed the quiz following the seminar.

2. Patients must complete the bariatric informational packet (obtained from us via email, fax, or USPS) and return the completed forms to The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery, 6001 SW 6th Ave, Ste 220, Topeka, KS 66615.

3. Patients must complete EMMI, an online bariatric surgery tutorial, prior to their initial consultation – OR - at our office on the day of their consultation. **Patients will be scheduled for the EMMI online tutorial when scheduled for a consultation with the surgeon**.

4. Patients must obtain psychological clearance for bariatric surgery.

5. **Insurance requirements for bariatric surgery vary greatly and can change at any time. While we do our best to inform you of the requirements that we are aware of when we schedule you for your initial consultation, there may be additional requirements that we are unaware of. You can help facilitate the process and avoid delays by familiarizing yourself with your insurance coverage regarding bariatric surgery.**

6. There may be additional medical clearances required by the surgeon after your consultation.

Please understand that until all documentation has been received and reviewed thoroughly by a surgeon, we are unable to determine if you are an appropriate candidate for weight loss surgery.

There is no guarantee, even after you have completed all of the requirements set forth herein, that we will proceed with surgery. It may be determined that you are not an appropriate candidate and / or you do not meet medical necessity to proceed with weight loss surgery.

We reserve the right to let you know that you are not a candidate for our surgical weight loss program.

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My Weight Loss Surgery Insurance Benefits

Questions to ask your insurance company:

√ Does my policy include coverage for weight loss surgery? YES____ NO ____
(Primary diagnosis code E66.01 – Morbid Obesity)

√ What procedure codes (CPT codes) are included?
____ CPT 43775 – Sleeve Gastrectomy
____ CPT 43644 – Roux-en-Y Gastric Bypass
____ CPT 43845 - Biliopancreatic Diversion with Duodenal Switch

√ Is it a requirement to have weight loss surgery at a **Center of Excellence** or **Blue Distinction** facility? YES____ NO____

√ Please verify specific information required. (Please check all that apply.)
____ Physician-supervised nutrition / diet / exercise counseling
If YES, how many months? _____
Is it a requirement that this be completed by an MD or DO? YES____ NO____
____ Is a separate dietician / nutrition evaluation required? YES____ NO____
____ Is documentation of history of obesity required? YES____ NO____
If YES, how many years? _____

√ What is my copay for a Specialist office visit? _____

√ Is a fax number available for my Provider to submit Predetermination? YES____ NO____
Fax #:_____

√ Name of Customer Service Representative I spoke to: _____

√ Date of phone call: _____

Please find the Customer Service phone number on the back of your insurance card and call to answer the questions above regarding your insurance benefits for weight loss surgery.

PLEASE NOTE: This worksheet is for patient use only. Completion of this worksheet will assist us to determine insurance benefits and requirements and does NOT guarantee coverage or eligibility for weight loss surgery.

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FINANCIAL / INSURANCE INFORMATION FOR BARIATRIC SURGERY

Please note that after we have received insurance authorization for your surgery, we will verify benefits and determine your estimated out-of-pocket financial responsibility. We will notify you of your estimated financial responsibility to **The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery**. Your out-of-pocket financial responsibility must be paid in full on or before your pre-operative appointment prior to surgery. This is payable in cash, cashier's check or credit card. If this amount is not paid on or before your pre-op date, your surgery will be rescheduled. You will be refunded for any overpayment or billed for any underpayment of your deductible/coinsurance due to The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery after claims have been processed.

Please be aware that the facility **(The University of Kansas Health System St. Francis Campus** will also verify benefits prior to surgery and will contact you regarding your estimated financial responsibility to the facility. The contact person at **The University of Kansas Health System St. Francis Campus** is the Centralized Scheduling Manager, PH: 785-270-5085.

After you have been notified of your out-of-pocket financial responsibility, your chart will then be given to the Surgery Scheduler to schedule your surgery.

If your insurance changes you must notify us before scheduling an appointment. If you arrive for an appointment and present new insurance information, your appointment will be rescheduled, as we will need time to verify benefits for bariatric services with your new insurance, and this process may take a few days to complete.

Thank you.

Bariatric Team Contact Information

Rachelle Garland, RN, BSN
Bariatric Nurse
rachelle.garland@kutopeka.com
PH: 785-295-5429
FAX: 785-270-7392

Brenda Holliday-Stanton
MBS Coordinator
brenda.holliday-stanton@kutopeka.com
PH: 785-270-7320
FAX: 785-270-7392

Bariatric Patient Questionnaire

Thank you for your interest in our bariatric surgery program. As you may have already discovered, the evaluation for this type of procedure can be quite complex and difficult. These questions are designed to help speed up your evaluation and assist in insurance authorization. Please answer all questions to the best of your ability.

Name_____ Date_____
First MI Last
Date of Birth____/____/____ Race_____ Age_____ SSN_____
Home Address_____
Street City State Zip
Home Phone #_____ Cell #_____ Work #_____
Place of Work_____
Patient Email Address_____
Insurance_____
Marital Status: S M D W Primary Care Physician_____
Primary Care Physician Office Phone # _____
Emergency Contact_____ Phone #_____

Allergies & Reactions:

_____ _____
_____ _____

Do you use tobacco currently: YES / NO Type _____(cigarettes, chew, E-cigarettes, vaping, etc.)
How much per day_____ How many years have you used tobacco _____
Have you ever used tobacco in the past: YES / NO When did you quit _____
Do you use marijuana: YES / NO How much per day_____
Do you drink alcohol: YES / NO How many drinks per week _____

FOR WOMEN ONLY:
Are you currently taking birth control? __YES What kind?_____
__NO
If 40 years of age or older, when was your last mammogram? _____

Medical History related to Obesity (Check all that apply/add any not listed)

___Diabetes - Year of diagnosis _____ Insulin? YES or NO
___Cardiomyopathy
___Coronary Heart Disease
___Cushing's Syndrome
___Osteoarthritis (where in body_____)
___Other _____
___Sleep Apnea
___Gastroesophageal Reflux Disease
___Hypertension
___Insomnia

Yes____ No____ CPAP?
Yes____ No____ Do you snore?
Yes____ No____ Are you excessively tired during the day?
Yes____ No____ Do you wake during the night feeling breathless?
Yes____ No____ Have you been told you stop breathing during sleep?
Yes____ No____ Do you have a history of hypertension?

If 50 years of age or older, when was your last colonoscopy? _____

Height_____ Weight_____ Body Mass Index (BMI)_____

What age did your weight problems begin?_____

Other Medical History

___Arthritis
___Cancer (Type) _____
___Emphysema/Chronic Bronchitis
___Heart Disease
___Heel Spurs
___History of Blood Clots/Clotting Disorder
___Kidney Disease
___Low Back Pain
___Obesity Hypoventilation Syndrome
___Plantar Fasciitis
___Polycystic Ovary Syndrome
___Pseudotumor Cerebrii
___Stress Urinary Incontinence
___Other_____
_____

Past Surgeries and Approximate Year:

_____ _____
_____ _____
_____ _____
_____ _____

Current Medications and Dosages:

_____ _____
_____ _____
_____ _____
_____ _____

Family History (list relationship in blank):

___Diabetes _____
___Blood Clots (DVT/PE) _____
___Cancer Relationship: _____ Type: _____
_____ _____
___Hypertension _____
___Clotting Disorders_____
___Obesity _____

Diet History: (<u>Please use attached form</u>)
List previous diet plans, approximate dates, duration, and weight loss achieved:

Have you had weight loss surgery in the past?
If yes, what kind, date of surgery and location? (Please have a copy of the operative report faxed to the office at (785) 228-4789 ATTN: Rachelle.)

Check or list any prescription medications taken for weight loss:

___Phen/Fen ___Phentermine ___Xenical
___Redux ___Meridia ___Amphetamines
____Other_____

I am___MOST INTERESTED in:
I am___ONLY INTERESTED in:
___Laparoscopic Sleeve Gastrectomy
___Laparoscopic Roux-en-Y Gastric Bypass (RNY)
___Biliopancreatic Diversion w/Duodenal Switch (BPD/DS)
I am___UNDECIDED about which procedure would be best for me.

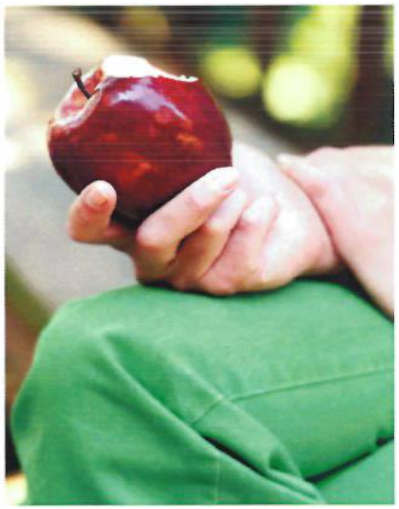
How did you hear about us?

_____ Physician (Physician's name)_____

_____ Website (Which website?) _____

_____ Other _____

DIET HISTORY



YEAR	AGE	NAME OF DIET/ MEDICATION	TIME ON DIET/ MEDICATION	WEIGHT AT START	WEIGHT LOST	DOCTOR OR DIETICIAN SUPERVISED?	WEIGHT REGAINED	REASON FOR DISCONTINUING
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	
						YES / NO	YES / NO	

DATE

NAME

ADDRESS

STREET

CITY STATE ZIP

THE UNIVERSITY OF KANSAS HEALTH SYSTEM ST. FRANCIS

GENERAL, VASCULAR & BARIATRIC SURGERY

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

REVIEW OF SYSTEMS

Check Yes (Y) or No (N) for each item if this condition is currently a problem.

CONSTITUTIONAL	Y	N	CARDIOVASCULAR	Y	N	GU	Y	N	ALLERGIES	Y	N
Unexpected Weight Change			Chest Pain			Difficulty Urinating			Environmental Allergies		
Chills			Leg Swelling			Pain with Intercourse			Food Allergies		
Fatigue			Feeling Heart Race			Flank (side) Pain			Immunocompromised		
Fever			**GI**			Urinary Frequency			**NEURO**		
Appetite Change			Abdominal Distention			Genital Sores			Dizziness		
HEENT			Abdominal Pain			Blood in Urine			Headaches		
Sore Throat			Anal Bleeding			Menstrual Problems			Light-headedness		
Trouble Swallowing			Blood in Stool			Pelvic Pain			Seizures		
Voice Change			Constipation			Urgency			Syncope (fainting)		
EYES			Diarrhea			Vaginal Bleeding			**HEME**		
Eye Discharge			Nausea			Vaginal Discharge			Adenopathy (disease of lymph node)		
Eye Pain			Rectal Pain			**MUSCLESKELETAL**			Bruises		
Eye Redness			Vomiting			Arthralgia (joint pain)			**PSYCHIATRIC**		
Visual Changes			**ENDOCRINE**			Back Pain			Confusion		
RESPIRATORY			Cold Intolerance			Gait Problems			Decreased Concentration		
Chest Tightness			Heat Intolerance			Joint Swelling			Mood Changes		
Cough						Neck Pain			Hallucinations		
Shortness of Breath						**SKIN**			Nervous/Anxious		
Stridor						Rash			Sleep Changes		
Wheezing						Wound					

YES **NO** Have you taken diet pills in the last two weeks?

YES **NO** Have you taken (or are you currently taking) Aspirin or Aspirin products in the past two weeks?

YES **NO** Have you taken (or are you currently taking) steroids (Prednisone) in the past six weeks?

YES **NO** Are you taking blood thinners (Coumadin or Warfarin?)

YES **NO** Are you taking diuretics or water pills?

YES **NO** Do you take a daily multivitamin?

If YES: PATCH_____PILL_____Brand: _____

YES **NO** Do you take additional Vitamin D?

If YES: Dose:_____

YES **NO** Do you take additional Iron?

If YES: Dose:_____

YES **NO** Do you take additional Calcium?

If YES: Dose:_____

THE UNIVERSITY OF KANSAS HEALTH SYSTEM
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Insurance Information

Please be prepared to provide your insurance card to the Receptionist to scan into our system. If you do not have your insurance card with you, you will be responsible for ALL fees until we receive a copy of your card.

PERSON RESPONSIBLE FOR PAYMENT

First Name _____ MI _____ Last Name _____ Street Address _____ City _____

Phone Number _____ State _____ Zip Code _____

PRIMARY INSURANCE INFORMATION Name of Insurance Co: _____

Policyholder Name _____ ____/____/____ Birthdate

Relationship to Patient _____ SSN _____ Policy ID # _____

Employer _____ Work phone _____

SECONDARY INSURANCE INFORMATION Name of Insurance Co: _____

Policyholder Name _____ ____/____/____ Birthdate

Relationship to Patient _____ SSN _____ Policy ID # _____

Employer _____ Work phone _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare / Other Insurance company benefits be made either to me or on my behalf to The University of Kansas Health System St. Francis General, Vascular & Bariatric Surgery. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or Intermediaries or Carriers any information needed for this or a related Medicare claim / Other Insurance company claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. **I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)**

If you don't have insurance coverage, payment is due when service is rendered unless you make arrangements prior to being seen by the provider.

I authorize the release of my medical records to my referring physician and / or specialty physician as deemed necessary.

Signature _____ **Date** _____

Parent / Guardian (if patient is under age 18): _____

THE UNIVERSITY OF KANSAS HEALTH SYSTEM
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Patient Name: _____ Date of Birth: _____

Dear Physician;

Your patient is interested in weight loss surgery and we are honored that they have chosen our bariatric program.

Per the request of the insurance company and / or our program requirements, this patient is required to complete a physician-supervised diet consisting of six (6) consecutive months (if a monthly visit is missed, the patient may not meet the insurance requirement – this varies per insurance.)

Please provide documentation regarding diet and exercise efforts within the past two years. If the patient is just beginning the physician-supervised diet, we have included a sample form for your convenience. You may use this form OR include the information in the medical record. **If using the form, please complete a new form for each monthly office visit and include the office visit notes for each date of service**.

Documentation must include:

- Monthly appointments with date of service and weight on that date
- Education regarding behavior modification
- Nutrition and exercise counseling to aid weight loss
- Notes regarding comorbidities related to patient's morbid obesity may be beneficial in obtaining approval for bariatric surgery

Please fax records to our office at Fax #: 785-270-7392. Please call with questions.

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Bariatric Team Contact Information

Rachelle Garland, RN, BSN
Bariatric Nurse
rachelle.garland@kutopeka.com
PH: 785-295-5429
FAX: 785-270-7392

Brenda Holliday-Stanton
Bariatric Program Coordinator
brenda.hollidaystanton@kutopeka.com
PH: 785-270-7320
FAX: 785-270-7392

Medically-Supervised Diet & Exercise Program

Patient Name:_____ DOB:_____ **Office Visit Date**:_____

Phone:_____

Height:_____ Weight:_____ BP:_____ Pulse:_____

Reason for Exam: **Morbid Obesity** Other:_____

SUBJECTIVE:_____

EXERCISE

Type:_____

Frequency:_____

DIET

Type:_____

DAILY CALORIC INTAKE GOAL:

☐ 1200-1500 ☐ 1500-1800 ☐ 1800-2000 ☐ Other_____

BEHAVIOR MODIFICATION:

Dietician_____ Psychologist_____ Support Groups_____

Internet/online_____ Other_____

OBJECTIVE FINDINGS: _____

PLAN/RECOMMENDATIONS:

_____ Encourage continued dietary modifications as noted above

_____ Discuss patient's progress toward his/her goals, including exercise and continued behavior modification efforts

_____ Recommend increased protein, decreased carbohydrate intake, and increased water intake in preparation for the post weight-loss surgery lifestyle

Other:

_____

_____

_____

_____

Physician Signature _____ Date_____