

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_



# **Weight Management Program**

## **Patient Packet**

*The questions asked on the following pages are very important. Please fill out the packet completely. The information you provide will be used by your surgeon's office to submit your case to insurance for approval of your surgery. Thank you.*

Welcome to the Mercer Health Weight Management Program. Our goal is to provide comprehensive services to assist you in your weight loss journey. We recognize there are many steps leading up to weight loss surgery, so we have developed a multidisciplinary team to help you. It is very important that you take an active role during this process. Your effort will ensure the process moves as efficiently as possible.

**In order to provide you with the best possible service, we must have the following information on file before scheduling your appointment in the Weight Management Center.** You may use this sheet as a checklist for your items.

- The Weight Management Patient Packet:** Complete all forms and provide all necessary information to take the next steps in the program.
- Insurance cards:** Include copies of **any/all** insurance cards, front and back.
- Medical Records:** Ask your doctor for the last 12 months of your medical records. These are the notes in your chart that the doctor makes during your visit. Ask your doctor for copies of your medical records that support your history of obesity and any diseases you have been treated for related to obesity.
- Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved.** This means you will need to see your doctor/ dietitian every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement.
- Physician letters of support:** Ask your primary care physician or any other physicians you have seen, such as cardiologists, pulmonologists, obstetricians/gynecologists, orthopaedic specialists, to write a letter of support. (See sample letter attached.)

Please bring the completed packet, copies of your insurance cards, medical records and letters with you when you attend an information seminar, or mail the information to the address below. If you have any questions, call the Weight Management Center at 419-678-8446 (thin).

We look forward to assisting you. Send completed information to:

**Mercer Health Weight Management Center**  
**800 West Main Street**  
**Coldwater, OH 45828**  
**Telephone: 419-678-8446**  
**Fax: 419-678-5996**



## INSURANCE INFORMATION

**PLEASE ATTACH COPIES OF ALL INSURANCE CARDS, BOTH FRONT & BACK,  
WHEN SUBMITTING THIS FORM.**

Disclaimer:

- The Mercer Health Weight Management Center is not responsible for incorrect information that the insurance company may provide to you.
- Completion of this form does not mean a guarantee of payment for services that may be rendered to you. Should the insurance company deny any services, you will be responsible for 100% of the charges.
- Completion of this form also does not mean that you are approved for weight loss surgery. A surgical preapproval can only be obtained once the necessary documentation is sent to the insurance company by a bariatric surgeon.

### PLEASE PRINT CLEARLY

<b>Fill in this information.</b>	
Patient Name	
Patient Date of Birth	
Insurance Name	
ID Number	
Group Number	
Subscriber Name	
Subscriber Employer	
Subscriber Date of Birth	
Provider Telephone Numbers (listed on back of card)	

**Reminder: Many insurance companies require a six-month physician supervised medical weight management program before surgery is approved.** This means you will need to see your doctor/ dietitian every month for six months, and your chart notes must include information about your height, weight and discussion/ recommendations for diet and exercise plan. Diet programs (Weight Watchers®, Jenny Craig®, etc) do not meet this requirement.

We will verify if your policy includes a medically supervised weight loss requirement and communicate this information to you. You may call the customer service number listed on your card to determine if you need this, and begin seeing your doctor every month for six months to help speed the process along. ***We do recommend that you contact the customer service number on your card in order to better understand the benefits specific to your insurance policy. Submission for approval for surgery does not occur until after the surgeon consult, and all required information is submitted to the insurance company.***

Some insurance policies have contract exclusions which mean that weight loss surgery will not be paid for even if it is medically necessary. The insurance company is not saying you don't need weight loss surgery, they are simply saying that it is not covered in your contract and they will not pay for it. Cash pay information is available by request. If you have questions regarding your insurance, please call the Weight Management Center at 419-678-8446.

Patient Name \_\_\_\_\_

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**AUTHORIZATION TO RELEASE MEDICAL RECORD**

**In order to submit for insurance approval and request records, please check the appropriate boxes. At my request, purpose for release:**

- Personal
- Continuing Care
- Insurance
- Legal
- Marketing
- Other: \_\_\_\_\_
  
- All Records

I hereby authorize release of my medical records:

TO: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

FROM: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorization request for release of medical information.

This consent will expire ninety (90) days after signed date below. I have given my consent freely, voluntarily and without prejudice.

I may revoke this authorization at any time providing I notify Mercer Health Weight Management Center, in writing to this effect.

I understand that any releases which were not made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

I understand that a photocopy facsimile of this authorization is considered acceptable in lieu of the original.

Treatment will not be conditioned on my providing this authorization unless the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

**This form must be completely filled out to process**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian/Power of Attorney/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Records prepared or transmitted/mailed by

\_\_\_\_\_  
Date

## **SAMPLE PHYSICIAN LETTER OF SUPPORT**

**Please obtain a letter of support from your primary care physician.**

**This form is a sample only and will not be accepted if the blanks are completed. Your physician must provide a separate letter of support.**

Date

PHYSICIAN NAME  
ADDRESS  
CITY, STATE ZIP CODE

RE: PATIENT NAME  
DATE OF BIRTH:

To Whom It May Concern:

The above named patient has been seen by our office for (\_\_\_\_) years. (He/she) suffers from the following co-morbidities: (List any diseases related to obesity such as hypertension, diabetes, sleep apnea, degenerative joint disease, etc.) (His/her) current weight is (\_\_\_\_lbs), height: (\_\_\_\_) and BMI: (\_\_\_\_). The patient has undergone the following weight loss attempts: (List any previous attempt, including Weight Watchers, Jenny Craig, Nutri-System, Slim Fast, etc., or any therapies you have prescribed).

I feel this patient would benefit from weight loss surgery because (he/she) has been unsuccessful losing weight with other diet methods, and (his/her) medical conditions will become life threatening if (he/she) does not get (his/her) weight under control.

I appreciate your consideration. Please contact me for further questions.

Sincerely,

Physician Name

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**PHYSICIAN INFORMATION**

Referring or Primary Care Physician Name:	Phone:
Address/City/State/Zip:	Fax:

Please list any other physicians whose care you are under.

	Name	Address	Phone
Cardiologist			
Gynecologist			
Orthopedist			
Psychiatrist			
Psychologist			
Pulmonologist			
Therapist			
Other			

**\*Reminder:** If your insurance company requires a **six month physician supervised medical weight management program** before surgery is approved, your family physician can assist you with this. In order to complete this program, you will need to have **monthly** appointments with your physician/ dietitian, and a documented treatment plan in your medical records that includes height, weight and discussion/recommendations for diet and exercise plan. You must complete these monthly appointments continuously for the amount of time your insurance policy requires. Diet programs (Weight Watchers ®, Jenny Craig ®, etc) many times do not meet this requirement. ***The Mercer Health Weight Management Center can provide forms your physician can use to document these visits.***

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**NUTRITION-RELATED HISTORY**

What is your current weight? \_\_\_\_\_ What is your current height? \_\_\_\_\_

How many years have you been overweight? \_\_\_\_\_

Were you overweight as a child? \_\_\_\_\_

Where is most weight located?  Face  Abdomen  Hips  Arms/Legs  All

Have you had weight loss surgery or other gastric surgery in the past?  Yes  No

If yes, please describe: \_\_\_\_\_

What was your greatest single weight loss in pounds? \_\_\_\_\_

How did you lose the weight? \_\_\_\_\_

How long did you sustain that weight loss? \_\_\_\_\_

Are you currently under a Physician's care for weight loss?  Yes  No

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Do you ever make yourself vomit after eating?  Yes  No

If yes, when was the last time you made yourself vomit after eating? \_\_\_\_\_

Have you ever used laxatives as a means of weight control?  Yes  No

Explain: \_\_\_\_\_

Do you currently have any medical restrictions on your diet?  Yes  No

If yes, what is restricted and why? \_\_\_\_\_

**Please Check and Provide Information for All That Apply**

**Medically Supervised Diet Programs:**

	No. Attempts	Date(s)	Time Length	Weight Loss	Amt. Regained
Medi-Fast					
Opti-Fast					
Fen/Phen					
Redux					
Meridia					
Behavior Modification					
Hypnosis					
Dietitian Recommended					

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**Please Check and Provide Information for All That Apply**

**Non-MD Supervised Programs:**

	<b>No. Attempts</b>	<b>Date(s)</b>	<b>Time Length</b>	<b>Weight Loss</b>	<b>Amt. Regained</b>
Weight Watchers					
Nutri-Systems					
Jenny Craig					
Other:					

**Liquid Diets:**

	<b>No. Attempts</b>	<b>Date(s)</b>	<b>Time Length</b>	<b>Weight Loss</b>	<b>Amt. Regained</b>
Slimfast					
Other:					

**Miscellaneous Diets:**

	<b>No. Attempts</b>	<b>Date(s)</b>	<b>Time Length</b>	<b>Weight Loss</b>	<b>Amt. Regained</b>
Low Calorie Diet					
Low Fat Diet					
High Protein/ Low Carb Diet					
Self Imposed Fasts					
Pritikin					
Richard Simmons					
Metabolife					
Herbal Life					
Other:					

**Please list ANY other attempts that you have made to lose weight that are not listed:**

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