Washington University Physicians
Washington University School of Medicine in St. Louis

Patient Name:_____ DOB: _____

Thank you for your interest in Washington University Bariatric "Weight Loss" Surgery.
Please read and complete entire form. Once we have received all required documents and tests, your request will be reviewed by our team and you will be contacted regarding your next steps.

Original Procedure:
☐ Lap Band ☐ Sleeve Gastrectomy ☐ Gastric Bypass ☐ Other: Date of Original Procedure:_____

Name of Surgeon who performed original procedure: _____

Name of Program/hospital were original procedure was performed: _____

Has original procedure already been revised? (circle) Yes or No If yes, date of revision:_____

☐ I have attached a copy of the front and back of my insurance card(s). **and**
- ☐ I called my insurance and they will cover revision of bariatric "weight loss" surgery.
- ☐ I called my insurance and they **WILL NOT** cover revision of bariatric "weight loss" surgery benefits.

I am requesting **Revision of previous bariatric "weight loss"** surgery because:

☐ I only want my Lap Band removed, I am **NOT** seeking revision to another weight loss surgery
☐ Nausea and Vomiting
☐ Slipped or Eroded Band shown in Barium Swallow
☐ Fistula shown in Barium Swallow
☐ Gained weight back or seeking greater weight loss
☐ Other: _____

The following documentation from Original Surgery is required:

☐ Operative note from your original weight loss surgery
☐ Operative note from any complications or revisions after surgery
☐ **Copy of Upper GI Barium Swallow in disc format within last 6 months**
☐ Referral letter from physician recommending revision.

- We do not accept revision packets via fax
- You must personally compile and mail the requested documents (copies not originals) listed above to our office in one large envelope
- Use this check list as your cover page.
- **Requests for revision that do not include Barium Swallow and Referral will not be processed**
- Please allow 30 to 45 business days for review.
- You may require additional testing and referrals to be ordered by our bariatric surgeons.

Thank you,
Washington University Bariatric Surgery
Please call our office if you have any questions.
314-454-7224 option 1

Mail to:
MIS Surgery – Bariatric Surgery
Revision Bariatric Surgery
660 South Euclid, Campus Box 8109
St. Louis, MO 63110

Thank you for choosing The Washington University's Surgical Weight Loss Program!
www.weightlosssurgery.wustl.edu

Current Height: _____feet _____ inch Weight: _____pounds BMI: (office use only _____)

Check all that apply to you: ☐ Diabetes ☐ Heart Disease ☐ Sleep Apnea ☐ High Blood Pressure

☐ Other _____

(Please note a diagnosed co-morbid condition may be required by insurance and/or our program.)

Print Full Legal Name:_____ **Date of Birth**:____/____/_____

Gender at birth: ☐ Male ☐ Female Gender you identify with: ☐ Male ☐ Female

SSN:_____ Maiden Name: _____ Preferred Language: _____

Cell #:_____ Work #: _____ Land line #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____@_____

Emergency Contact: (first/last) _____

Phone: _____ Relation: _____

Primary Physician: (first/last) _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ I do not have a Primary Care Physician.

Referring Physician: (first & last) _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

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Please include a copy of the front and back of all insurance cards.

Primary Insurance Name: _____ Phone: _____

PO Box: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Policy Holder's Employer: ☐ BJC ☐ Wash.U. ☐ Other: _____

Policy Holder Relation: Spouse, Parent, Self (if "Self" skip to "Secondary Insurance")

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address if different from patient:_____

If Tri-care insurance - Branch & Member ID SSN: _____

Call insurance. Is weight loss surgery covered? **Yes** ☐ **No** ☐ **(Revisions must have insurance coverage)**

Secondary Insurance Name: _____ Phone: _____

PO Box: _____ City: _____ State: _____ Zip: _____

ID Number: _____ Group Number: _____

Policy Holder's Employer: ☐ BJC ☐ Wash.U. ☐ Other: _____

Policy Holder Relation: Spouse, Parent, Self (if "Self" skip to "Secondary Insurance")

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Address if different from patient:_____

If Tri-care insurance - Branch & Member ID SSN: _____

Call insurance. Is weight loss surgery covered? **Yes** ☐ **No** ☐ **(Revisions must have insurance coverage)**

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