SUPPLEMENTAL APPLICATION

PHYSICIANS & SURGEONS

BARIATRIC SURGERY
Claims-Made and Reported Coverage

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

1.	Applicant Name:

II. TRAINING and EDUCATION

1.	Are you currently certified by the American Society for Bariatric Surgeons (ASBS)?	☐ Yes ☐ No
2.	Have you completed the ASBS course: "Essentials of Bariatric Surgery"? If so, when?	☐ Yes ☐ No
3.	How long have you been performing bariatric procedures?	years months

III. PROCEDURES

1.	What percentage of your practice is bariatric surgery? %	
2.	Do you perform bariatric surgery at a location that is part of the Bariatric Surgery Centers of Excellence Program? If so, what percentage? %	☐ Yes ☐ No
3.	Please identify the type of bariatric surgical procedures performed: (check all that apply)	

	NUMBER OF PROCEDURES	
	Last 12 Months	Next 12 Months
☐ Open Adjustable Gastric Banding		
☐ Laparoscopic Adjustable Gastric Banding		
☐ Open Vertical Banded Gastroplasty		
☐ Laparoscopic Vertical Banded Gastroplasty		
☐ Open Standard Roux Gastric Bypass		
☐ Laparoscopic Standard Roux Gastric Bypass		
☐ Open Long-limb Roux Gastric Bypass		
☐ Laparoscopic Long-limb Roux Gastric Bypass		
☐ Open Biliopancreatic Diversion		
☐ Laparoscopic Biliopancreatic Diversion		
☐ Open Duodenal Switch		
☐ Laparoscopic Duodenal Switch		
☐ Other		

IV. PATIENT SELECTION / INFORMATION

1.	Please provide your general patient selection and acceptance guidelines: A. BMI: average B. Patient age: youngest years average years C. Please describe other selection and acceptance guidelines:
2.	Please attach a copy of your Informed Consent form for bariatric procedures.
3.	Please identify the types of pre-operative and post-operative support that you provide to your bariatric patients: ☐ Nutrition Counseling ☐ Respiratory Therapy ☐ Mental Health ☐ Other (identify)

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VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. This applicant understands that incorrect information could void coverage.

Signature:	Date:
Printed Name:	

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