

AUTHORIZATION TO SHARE HEALTH INFORMATION

I, _____, allow my doctor(s), my health plan or insurers, and any other healthcare providers to give medical information relating to my use or need for the REALIZE™ Adjustable Gastric Band to Lash Group Healthcare Consultants. Lash Group Healthcare Consultants run the Ethicon Endo-Surgery Reimbursement Support Program.

This information can include spoken or written facts about my health or payment benefits I may have. It can include copies of records from my healthcare providers or health plans about my health or care.

Lash Group Healthcare Consultants will use and give out this information to check to see if I have coverage for the REALIZE™ Adjustable Gastric Band and to run the Program. Lash Group Healthcare Consultants may also give my information to others if they first take out anything that identifies me.

I know that people who work for and with Lash Group Healthcare Consultants may use and see my information, but they may use it only as allowed in this form. I understand that Lash Group Healthcare Consultants will make every effort to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.

This Authorization will last for 3 years after the date I sign this form. If I change my mind before that time, I can tell my doctor, healthcare provider, and/or my insurer in writing that I do not want them to share any more information with Lash Group Healthcare Consultants, but it will not change any actions they took before I told them. I know that I have a right to see or copy the information my healthcare providers or insurers have given to Lash Group Healthcare Consultants.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way my healthcare providers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the Program.

I understand that Lash Group Healthcare Consultants does not promise to find ways to pay for my REALIZE™ Adjustable Gastric Band surgery, and I know that I may have to pay the costs of my care.

Patient Sign Here _____ Date: _____
(If the patient cannot sign, patient's representative must sign below)

Patient Name: _____

By: _____
(Signature of person signing for patient)

Describe relationship to patient and right to act for patient:

REALIZE™ Adjustable Gastric Band Benefit Verification

Completed form may be faxed to REALIZE™ Band Reimbursement Support at 877-606-2255.

For more information regarding reimbursement

Please contact the REALIZE™ Band Reimbursement Support Program at 1-866-REALIZE.

Patient Information

Patient Name: _____

Social Security #: _____

Male Female

Address: _____

City, State, ZIP: _____

Daytime Phone #: _____

Date of Birth: _____

Physician Information

Physician Name: _____

Site Name: _____

Practice Address: _____

City, State, ZIP: _____

Contact Name: _____

Phone #: _____ Fax #: _____

NPI #: _____ Tax ID #: _____

Patient Insurance Information

Primary Insurance Information (including Medicaid or Medicare)

Subscriber Name: _____

Subscriber Date of Birth: _____

Payer Name: _____

Policy #: _____

Group #: _____

Payer Phone #: _____

Payer Provider ID#: _____

Secondary Insurance Information

Subscriber Name: _____

Subscriber Date of Birth: _____

Payer Name: _____

Group #: _____

Policy #: _____

Payer Phone #: _____

Payer Provider ID#: _____

Facility Information

Site Name: _____

Practice Address: _____

City, State, ZIP: _____

Contact Name: _____

Phone #: _____ Fax #: _____

NPI #: _____ Tax ID #: _____

Clinical Information

Patient BMI: _____

Patient Diagnosis – Primary:

278.01 Morbid Obesity

Other: _____

Additional Diagnoses (please check all that apply):

783.49 Overeating 327.23-29 Sleep Apnea

401 Essential Hypertension 462 Sore Throat

530.81 Reflux 783.49 Overeating

784.49 Hoarseness 786.07 Wheezing

786.2 Chronic Cough 787.03 Regurgitation

787.1 Heartburn 787.3 Belching

Previous Weight Loss Regimens? (Please describe):

The information contained in this document is provided for your informational purposes only and represents no statement, promise, or guarantee by Ethicon Endo-Surgery concerning levels of reimbursement, payment or charge. Similarly, all billing codes and revenue codes mentioned above are supplied for information purposes only and represent no statement, promise or guarantee by Ethicon Endo-Surgery that these codes will be appropriate or that reimbursement will be made. It is the responsibility of the health services provider to confirm the patient's insurance coverage prior to performing the bariatric procedure and related services