



Bariatric Surgery Insurance Verification

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone (home): _____ Telephone (work): _____

Telephone (cell): _____ preferred phone: home work cell

Email: _____ @ _____ . _____

Date of Birth: ____/____/____ Sex: Male Female

SSN: _____

Current Height: _____ ft. _____ inches Current Weight: _____ lbs.

Primary Insurance Company: _____

Employer: _____

Policy holder: _____ Date of Birth (if not self) _____

Secondary Insurance Company: _____

Employer: _____

Policy holder: _____ Date of Birth (if not self) _____

I grant WellSpan Health and/or Apple Hill Surgical Associates permission to contact the insurance carriers listed above on my behalf to verify benefits for bariatric surgery.

Signature _____ Date _____