

**Healthcare Facility Bariatric
Supplemental Application**



PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Legal Entity Name: _____

Address: _____

City, State, ZIP: _____

- 1. Is this facility designated as a Center of Excellence in Bariatrics? Yes No
- 2. Types of open bariatric surgeries:
 - a. Gastrointestinal procedures
 - b. Biliary surgery procedures
 - c. Vertical banded gastroplasty
 - d. Roux-en-Y gastric bypass
 - e. Extensive gastric bypass (Biliopancreatic diversion)
 - f. Other: _____
- 3. Types of Laparoscopic bariatric surgeries:
 - a. Lap banded
 - b. Lap stapled
 - c. Lap Roux-en-Y
 - d. Other: _____
- 4. Is staff credentialed for bariatric procedures? Yes No
- 5. Does the facility require and utilize a multidisciplinary team including surgeon, anesthesiologist, psychiatrist, eating disorder specialist, internist, cardiologist, dietician, exercise physiologist, etc. for each patient? Yes No
- 6. Is the facility properly equipped to accommodate severely obese patients (chairs, beds, scales, lifts, operating room equipment, bariatric instruments, commodes, wheelchairs, radiology and other diagnostic equipment)? Yes No
- 7. Are there established fall and emergency procedures in place? Yes No
- 8. Are there established follow up and call back procedures in place? Yes No
- 9. Is proper patient selection criteria utilized and documented? Yes No
- 10. Is proper informed consent executed and documented? Yes No
- 11. Please provide a contact name and phone number to schedule a risk management survey.

 Contact Name

 Phone

12. Provide marketing/advertising materials (i.e. newspaper and magazines, brochures, emails, website, etc.).

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):

Agent: _____

Phone: _____

Agency: _____

Fax: _____

Address: _____

Email: _____

License No.: _____

Signature: _____