



BARIATRIC SURGERY UNDERWRITING GUIDELINES

Please provide additional remarks and/or explanation on page 2.

<u>SURGEON</u>			
NAME:			SPACE RESERVED FOR MAG MUTUAL UNDERWRITNG
<u>Types and numbers of Procedures performed:</u>	Open	Laporoscopic	
S1. Roux-en-Y			
S2. Laporoscopic Adjustable Gastric Banding			
S3. Vertical Banded Gastroplasty			
S4. Biliopancreatic Diversion			
S5. Other bariatric procedures			
	Where ?	How long?	
S6. Completed Accredited Bariatric Surgery Residency or Fellowship			
S7. Completed advanced laporoscopic fellowship including lap bariatric procedures			
	YES	NO	
S8. Documentation of 20 proctored Bariatric surgeries. Provide documentation of proctored cases.			
S9. Performed a minimum of 100 documented Bariatric surgeries. Provide documentation of outcomes.			
S10. Primary bariatric surgeon for a minimum of 50 cases annually. Provide documentation of outcomes.			
S11. Board Certified General Surgeon by ACS.			
S12. Meets privileging guidelines of the American Society for Bariatric Surgery.			
<u>PROGRAM</u>			
<u>Patient Selection Criteria</u>	YES	NO	SPACE RESERVED FOR MAG MUTUAL UNDERWRITNG
P1. BMI Standards:			
* >35 with comorbidities			
* >40 for weight loss			
P2. 100 pounds over normal body weight			
P3. Pediatric/Adolescent Patients (under 18 years old)?			
P4. Patients over 65 years old?			
P5. Extensive Pre-Op Evaluation Program – send copy of program.			
* Co-morbidities; extensive lab work			
* Psychology/psychiatry testing, evaluation and consults			
* Pulmonary/cardiology consults			

* Dietitian/nutritionist consults			
* Substance abuse screening			
* Assess patient pre-op compliance. Provide document.			
* Formal Staff Education Program			
P6. Extensive Patient Education Program – send copy of program.			
* Videos/reading material/quizzes			
* Health, not cosmetic			
* Diet/nutrition education			
* Support group			
* Family participation			
* Extensive informed consent			
* Weight loss, exercises, pre-op			

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P7 . Extensive Follow-Up/Post-Op Evaluation Program			
* Percentage of patients followed at 1 week			
* Percentage of patients followed at 3 months			
* Percentage of patients followed at 6 months			
* Percentage of patients followed at 1 year			
* Percentage of patients followed annually for life			

FACILITY

Facilities where procedures are performed:

<u>Name of Facility</u>	<u>ASBS/SCI Accreditation</u>	<u>City/State</u>
		City, S
	YES	NO
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F1. Does each facility have all equipment necessary to accommodate this class of patient?		
F2. Does each facility have imaging equipment in facility designed for morbidly obese patients?		
F3. Is each facility equipped with furniture, Imaging devices, OR equipment and emergency supplies suitable for morbidly obese patients.		
F4. Does each facility have specialists available in facility, to include pulmonology, interventional radiology and cardiology to treat unexpected complications?		
F5. Is each facility fully equipped to handle morbidly obese Critical Care patients including, ICU and MD Anesthesia?		
F6. Does each facility have Nursing Staff specially trained to treat this class of patient?		
F7. Is each facility certified by ASBS/SCI?		
F8. Is an ASBS/SCI accreditation request pending?		

Additional Remarks/Explanation (please refer to section and question):

Please include a summary of your Professional Liability Claim History using the Claim Summary form attached (please duplicate if needed).

I hereby declare that the information provided in this Questionnaire is true and complete to the best of my belief, knowledge and recollection and that I have not willfully concealed or misrepresented any material facts or circumstances.

Signature: _____

Date: _____

Name: _____

Please Print

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