



PATIENT INSURANCE VERIFICATION REQUEST

Fax: 1.855.537.5825 or 770.590.3575 Hotline Phone: 1.855.882.8903

New Request: ___ Re-Verification: ___ Additional Applications: ___ New Insurance: ___ Sales Executive: ___

FACILITY AND PHYSICIAN INFORMATION

| | | Physician | Facility |
|---|--|-----------------------|----------|
| Physician Name: | | | |
| Physician Specialty: | | NPI: | |
| Facility Name: | | Tax ID: | |
| Facility Address: | | PTAN (Medicare #): | |
| City, State, Zip: | | Medicaid #: | |
| Contact Name: | | Phone #: | |
| Primary Care Physician: | | Fax #: | |
| Primary Care Physician Phone: | | Salesforce Account #: | |
| Physician Office (POS 11) ___ Hospital Outpatient (POS 22) ___ Ambulatory Surgical Center (POS 24) ___ Home (POS 12) ___ Assisted Living (POS 13) ___ Nursing Facility (POS 32) ___ Critical Access Hospital ___ Hospital Inpatient (POS 21) ___ Other _____ | | | |

PATIENT INFORMATION

| | |
|---------------------------|--|
| Patient Name: | Patient Date of Birth: |
| Patient Address: | Is the patient currently in a Skilled Nursing Facility? Yes ___ No ___ |
| Patient City, State, Zip: | Is the patient currently in a surgical global period? Yes ___ No ___ |

INSURANCE INFORMATION

| Primary | Secondary |
|---|--|
| <i>Is provider and facility in network? Yes ___ No ___</i> | <i>Is provider and facility in network? Yes ___ No ___</i> |
| Payer Name: | Payer Name: |
| Policy #: | Policy #: |
| Payer Phone #: | Payer Phone #: |
| Worker's Compensation Adjuster or VA Case Manager Name & Phone #: | |

Please fax system face sheet and insurance cards. If Commercial/Medicare Advantage/Medicaid/Managed Medicaid fax 4 weeks of clinical notes.

PRODUCT (CHECK)

| | | |
|--|--|---|
| EPIFIX or EPIFIX Mesh Allograft (Q4186) <input type="checkbox"/> | EPICORD or EPICORD Expandable Allograft (Q4187) <input type="checkbox"/> | AMNIOFIX Allograft (J3590) <input type="checkbox"/> |
|--|--|---|

WOUND INFORMATION

| Wound Type (check) | ICD-10 Codes | Test Results |
|---|--|--|
| Diabetic Foot Ulcer <input type="checkbox"/> | Primary: <input type="text"/> | HbA1C: <input type="text"/> Date: <input type="text"/> |
| Venous Leg Ulcer <input type="checkbox"/> | Secondary: <input type="text"/> | ABI: <input type="text"/> Date: <input type="text"/> |
| Chronic Ulcer <input type="checkbox"/> | Wound Description | Serum creatinine: <input type="text"/> Date: <input type="text"/> |
| Dehiscd Surgical Wound <input type="checkbox"/> | | Pre-Albumin/Albumin: <input type="text"/> Date: <input type="text"/> |
| Mohs Surgical Wound <input type="checkbox"/> | | |
| Other: <input type="checkbox"/> | Location of Ulcer: <input type="text"/> | |
| | Duration of Ulcer: <input type="text"/> | |
| | Post Debridement Total Size of Ulcers (cm ²): <input type="text"/> | |

AUTHORIZED HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED

I certify that I have received the necessary patient authorization to release the medical and/or patient information to MIMEDX.

Authorized Signature: _____

Date: _____

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