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:	NPI:		
Physician Specialty:	Tax ID:		
Facility Name:	PTAN (Medicare #):		
Facility Address:	Medicaid #:		
City, State, Zip:	Phone #:		
Contact Name:	Fax #:		
Primary Care Physician:			
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
Is provider and facility in network? Yes____ No____	***Is provider and facility in network? Yes____ No____***
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)	☐	EPICORD or EPICORD Expandable Allograft (Q4187)	☐	AMNIOFIX Allograft (J3590)	☐

WOUND INFORMATION

Wound Type (check)		ICD-10 Codes	Test Results	
Diabetic Foot Ulcer	☐	Primary:	HbA1C:	Date:
Venous Leg Ulcer	☐	Secondary:	ABI:	Date:
Chronic Ulcer	☐	**Wound Description**	Serum creatinine:	Date:
Dehisced Surgical Wound	☐	Location of Ulcer:	Pre-Albumin/Albumin:	Date:
Mohs Surgical Wound	☐	Duration of Ulcer:		
Other:	☐	Post Debridement Total Size of Ulcers (cm^2):		

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: