



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: _____
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FACILITY AND PHYSICIAN INFORMATION

Physician Name:	Physician	Facility
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)
 EPICORD or EPICORD Expandable Allograft (Q4187)
 EPIEFFECT Allograft (Q4278)
 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: _____
Dehiscd 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: _____

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