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:	Salesforce Account #:		
Primary Care Physician Phone:			

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) ☐ 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:
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: