PATIENT INSURANCE VERIFICATION REQUEST

Fax: 1.855.537.5825 or 770.590.3575 Hotline Phone: 1.855.882.8903

All fields highlighted in **BOLD** are mandatory. Fields not bolded may be completed directly or included as an attachment (e.g., Patient Fact Sheet).

New Request: ☐ **Re-Verification:** ☐ **Additional Applications:** ☐ **New Insurance:** ☐ **Benefits Only:** ☐ Sales Executive: _____

☐ **Check this box if you would like us to attempt authorization/pre-determination if the policy does not cover this product** (clinical documentation required)**.**

FACILITY AND PHYSICIAN INFORMATION

Please fill out both columns

	PHYSICIAN	FACILITY
Physician Name:		
Physician Specialty:		
Facility Name:		
Facility Address:		
City, State, Zip:		
Contact Name:		
Primary Care Physician:		
Primary Care Physician Phone:		
NPI:		
Tax ID:		
PTAN (Medicare #):		
Medicaid #:		
Phone #:		
Fax #:		
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**
In Network? Facility Yes ☐ No ☐ Provider Yes ☐ No ☐	In Network? Facility Yes ☐ No ☐ Provider Yes ☐ No ☐
Payer Name:	Payer Name:
Facility Name:	Facility Name:
Policy #:	Policy #:
Payer Phone #:	Payer Phone #:

Worker's Compensation Adjuster or VA Case Manager Name and 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)**
☐ **CELERA Allograft (Q4259)**

WOUND INFORMATION

WOUND TYPE (check)	
Diabetic Foot Ulcer	☐
Venous Leg Ulcer	☐
Chronic Ulcer	☐
Dehisced Surgical Wound	☐
Mohs Surgical Wound	☐
Other:	☐

WOUND 1 DESCRIPTION
Location of Ulcer:
Duration of Ulcer:
Post Debridement Total Size of Ulcers (cm²):
WOUND 2 DESCRIPTION
Location of Ulcer:
Duration of Ulcer:
Post Debridement Total Size of Ulcers (cm²):

ICD-10 CODES	
Primary:	**Secondary:**
TEST RESULTS	
HbA1C:	Date:
ABI:	Date:
Serum creatinine:	Date:
Pre-Albumin/Albumin:	Date:
Procedural Date:	

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:** _____

Disclaimer: This document has been prepared for providers using MIMEDX and is intended for informational purposes only. This is a limited patient support program for MIMEDX patients only. It does not represent a statement, promise or guarantee by MIMEDX Group, Inc., concerning levels of reimbursement, payment or charges. It is not intended to increase or maximize reimbursement. The decision as to how to complete a reimbursement claim form, including amounts to bill, is exclusively the responsibility of the provider.