



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:	NPI:	
Physician Specialty:	Tax ID:	
Facility Name:	PTAN (Medicare #):	
Facility Address:	Medicaid #:	
City, State, Zip:	Phone #:	
Contact Name:	Fax #:	
Primary Care Physician:	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

In Network? Facility Yes ☐ No ☐ Provider Yes ☐ No ☐

Payer Name:

Facility Name:

Policy #:

Payer Phone #:

SECONDARY

In Network? Facility Yes ☐ No ☐ Provider Yes ☐ No ☐

Payer Name:

Facility Name:

Policy #:

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)** ☐ **EPIXPRESS Allograft (Q4361)** ☐ **AMNIOFIX Allograft (J3590)** ☐ **CELERA Allograft (Q4259)** ☐ **EMERGE Allograft (Q4297)**

WOUND INFORMATION

WOUND TYPE (check)	WOUND 1 DESCRIPTION	ICD-10 CODES
Diabetic Foot Ulcer ☐	Location of Ulcer:	Primary: Secondary:
Venous Leg Ulcer ☐	Duration of Ulcer:	TEST RESULTS
Chronic Ulcer ☐	Post Debridement Total Size of Ulcers (cm²):	HbA1C: Date:
Dehiscd Surgical Wound ☐	WOUND 2 DESCRIPTION	ABI: Date:
Mohs Surgical Wound ☐	Location of Ulcer:	Serum creatinine: Date:
Other: ☐	Duration of Ulcer:	Pre-Albumin/Albumin: Date:
	Post Debridement Total Size of Ulcers (cm²):	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:** _____

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