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

☐ **EPIFIX or EPIFIX Mesh Allograft (Q4186)** ☐ **EPICORD or EPICORD Expandable Allograft (Q4187)** ☐ **EPIEFFECT Allograft (Q4278)** ☐ **EPIXPRESS Allograft (Q4361)**

☐ **CELERA Allograft (Q4259)** ☐ **EMERGE Allograft (Q4297)** ☐ **RegenKit® Wound Gel (G0465)**

WOUND INFORMATION

WOUND TYPE

☐ **Diabetic Foot Ulcer**
☐ **Chronic Diabetic 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:** _____