



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						SECONDARY						
In Network?	Facility	Yes	No	Provider		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)** **CHORIOFIX™ (Q4412)**

WOUND INFORMATION

WOUND TYPE	WOUND 1 DESCRIPTION		ICD-10 CODES	
	Location of Ulcer:	Duration of Ulcer:	Primary:	Secondary:
Diabetic Foot Ulcer	_____	_____		
Chronic Diabetic Ulcer	_____	_____		
Venous Leg Ulcer	_____	_____		
Chronic Ulcer	WOUND 2 DESCRIPTION		TEST RESULTS	
Dehisced Surgical Wound	Location of Ulcer:	_____	HbA1C:	Date:
Mohs Surgical Wound	Duration of Ulcer:	_____	ABI:	Date:
Other _____	Post Debridement Total Size of Ulcers (cm ²):	_____	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: _____

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