**Fax form to: 855-552-3776**

PalinGen
an AmnioTechnology LLC Product

# VERIFICATION OF BENEFITS

Office Name:
Address:

Phone:
Fax:

Physician Name:
NPI:
Tax ID Number:
BCBS Provider ID#:

**Russell Health, Inc.**
Ryan Salvino
rsalvino@russellhealth.com
**P:** (630) 297-3377

## PATIENT INFORMATION

Patient Name:
Date of Birth: Order Date:
Insurance Provider:
Insurance ID: Insurance Phone:

**REQUIRED INFO:**

- Patient Demographics/Face Sheet
- Copy of Insurance Cards (front and back)
- Most Recent Encounter Notes

Is the patient currently in a Skilled Nursing Facility? ☐ Yes ☐ No

- If yes, the product is not separately payable by Medicare if the patient is within 100 days of the Part A benefit. Contact SNF for payment.

Is the patient currently in a Surgical Global Period? ☐ Yes ☐ No

- If yes, what is the CPT code for the procedure? _____ Surgery Date? _____

## WOUND INFORMATION

| Product | WOUND #1 | WOUND #2 | WOUND #3 |
|---|---|---|---|
| ☐ PalingGen Membrance Q4173<br>✔PalinGen SportFlow Q4174 | ☐ Diabetic Ulcer<br>☐ Venous Ulcer<br>☐ Chronic Ulcer<br>☐ Pressure Ulcer<br>☐ Dehisced Surgical Wound<br>☐ Burn | ☐ Diabetic Ulcer<br>☐ Venous Ulcer<br>☐ Chronic Ulcer<br>☐ Pressure Ulcer<br>☐ Dehisced Surgical Wound<br>☐ Burn | ☐ Diabetic Ulcer<br>☐ Venous Ulcer<br>☐ Chronic Ulcer<br>☐ Pressure Ulcer<br>☐ Dehisced Surgical Wound<br>☐ Burn |
| **(Diagnostic Codes)** | | | |
| Duration of Wound/Ulcer | | | |
| Location / Body Part | ☑ L ☐ R / | ☐ L ☐ R / | ☐ L ☐ R / |
| Length x Width (sq/cm) | X | X | X |
| Stage | ☐ I ☐ II ☐ III ☐ IV | ☐ I ☐ II ☐ III ☐ IV | ☐ I ☐ II ☐ III ☐ IV |
| Thickness | ☐ Partial ☐ Full | ☐ Partial ☐ Full | ☐ Partial ☐ Full |
| ICD10 Codes | | | |
| CPT Codes | | | |

## PRESCRIBER APPROVAL

By my signature below, I attest that I am treating the patient identified on this form and the requested skin substitute is medically necessary based on my examination/treatment of the patient. I am maintaining a copy of this order for my patient's chart and will make it available upon request. I certify that I have received the necessary patient authorization to release the medical and/or patient information for this service.

**Prescriber Signature:** _____ **Date:** _____