Patient Insurance Support Form

Please fax completed form to toll-free HIPAA-Compliant Fax: 855.840.8080

SKYE® BIOLOGICS

Skye Sales Rep _____

Facility Information

Place of Service: ☐ Office ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Other _____

Facility name of where procedure will be performed | Phone | NPI

Address / City / State / Zip | Fax | TIN

Contact Name | Medicare Admin Contractor | PTAN

Physician Information

Physician Name | Phone | NPI

Address / City / State / Zip | Fax | TIN

Contact Name & Phone | Medicare Admin Contractor | PTAN

Specialty | Site Name (if different from above)

Patient Information

Patient Name | Date of Birth | Phone

Address / City / State / Zip | OK to Contact Patient? YES ☐ NO ☐

Insurance Information - Please include a front & back copy of patient insurance card.

Primary Insurance | Policy Number

Subscriber Name | Subscriber DOB | Type of Plan (HMO/PPO/Other) | Insurance Phone Number

Does Provider Participate with Network? YES ☐ NO ☐ Not Sure / Please verify (NPI and TIN must match billing address) ☐

Secondary Insurance | Policy Number

Subscriber Name | Subscriber DOB | Type of Plan (HMO/PPO/Other) | Insurance Phone Number

Does Provider Participate with Network? YES ☐ NO ☐ Not Sure / Please verify (NPI and TIN must match billing address) ☐

If patient has additional/tertiary insurance, please send copies separately; All Workers Comp cases must have claim number and adjuster's name and phone/contact info in order to process.

Wound Information

Wound Type: ☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐ Pressure Ulcer ☐ Traumatic Burns ☐ Radiation Burns ☐ Dehisced Surgical Wound ☐ Necrotizing Faciitis

☐ Other: _____ Wound Size(s): _____

☐ If Prior Authorization is required, check here to allow us to work with the payer on your behalf. **Please attach a copy of the patient's clinical records.**

Product HCPCS: ☐ Q4277 (WoundPlus™) Date of Application: _____ Anticipated # of Applications: _____

Application CPT(s): ☐ 15271 ☐ 15272 ☐ 15273 ☐ 15274 ☐ 15275 ☐ 15276 ☐ 15277 ☐ 15278

ICD-10 Diagnosis Code(s): _____

Is patient currently residing in SNF? YES ☐ NO ☐

Is patient under a surgical Global Period? YES ☐ NO ☐ If Yes, please indicate CPT code & Date of Procedure: CPT: _____ Date: _____

Physician Agreement

By signing below, I certify that I have received the necessary patient authorization to release the medical and/or other patient information referenced on the form relating to the above referenced patient. This information is for verifying insurance coverage, seeking reimbursement, and sole purpose of claim support.

Physician or Authorized Signature: _____ **Date:** _____

Please contact 800.759.9102 with any questions. Please fax completed form to toll-free HIPAA-Compliant Fax: 855.840.8080