IVR

Facility Information

Distributor / Company: _____

Physician Name:_____Practice Name: _____
Physician PTAN:_____Practice PTAN: _____

Physician NPI:_____Practice NPI_____TAX ID#_____

Office Contact Name: _____ Office Contact Email: _____

Patient Information

Patient Name: _____Patient DOB: _____

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____Member ID: _____

Copy of Front and Back of Insurance card attached: **Yes or No**

Place of Service: (11) Office (12) Home (13) Assisted Living Other: _____

Is the patient currently residing in a Nursing Home OR Skilled Nursing Facility: **Yes or No**

If yes, has it been over 100 days? **Yes or No**

Is this patient currently under a post-op period? **Yes or No**

If yes, please list CPT code(s) of previous surgery: _____Surgery Date: _____

Procedure Information

Procedure Date: _____ Wound Size: L__ W__Total: _

Wound location: _____ Size of Graft Requested: _____

ICD-10	CPT	HCPCS (when applicable
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

MUST INCLUDE: Front/Back of Insurance Card * Demographic Sheet * Chart Notes

Please return via email to ivr@medlifesol.com