EXAMPLE IVR FORM
****We suggest pre-filling Office Information and making copies**

Patient Insurance Support Form

Please fax completed form to toll-free HIPPA compliant fax: 223.336.4751
Or email to Reimbursement@AdvancedSolution.Health

Sales Rep MSC Wound Care

Facility Information

Place of Service: ☑ Office ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Other
Facility Name: John Smith Foot & Ankle Care
Address: 1234 Footcare Rd, San Jose CA 95110
Contact Name: Jane Doe - Office Manager
Phone: 650-555-1234
Fax: 650-555-1122

Medicare Admin Contractor:
NPI: 84-111111111 (Group)
TIN: 8181111110
PTAN:

Physician Information

Physician Name: Dr John Smith
Address: See Above
Phone:

Fax:
NPI: 84-010101101 (Provider NPI)
TIN:

Patient Information

Patient Name: Josephina Doety
Address: [City / State / Zip] 1122 Patient Address Wy, Palo Alto CA 94306
Date of Birth: 01/23/1954

Phone: 650-555-5551
OK to Contact Patient?: ☐ Yes ☑ No

Insurance Information

Primary Insurance Medicare Part B
Subscriber Name:
Policy Number: 1234-4321-1234
Subscriber DOB: 01/23/1954
Type of Plan: ☐ HMO ☐ PPO ☐ Other
Insurance Phone Number: 800-555-5555
Does Provider Participate with Network?: ☑ Yes ☐ No
Not Sure (Please verify)

Secondary Insurance United Health Care
Subscriber Name:
Policy Number: 1111-2222-3333
Subscriber DOB: 01/23/1954
Type of Plan: ☐ HMO ☐ PPO ☐ Other
Insurance Phone Number: 800-555-5540
Does Provider Participate with Network?: ☑ Yes ☐ No
Not Sure (Please verify)

Wound Information

Wound Type: ☑ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐ Pressure Ulcer ☐ Traumatic Burns ☐ Radiation Burns ☐ Necrotizing Faciitis ☐ Dehisced Surgical Wound ☐ Other
Wound Size(s): 2x2
Application CPT(s):
Date of Procedure: 10/02/2024
ICD-10 Diagnosis Code(s):
Product Information: ☑ CompleteAA ☐ Membrane Wrap Hydro ☐ Membrane Wrap ☐ WoundPlus ☐ CompleteFT ☐ Other:

Additional Information

Is the patient currently residing in SNF? ☐ Yes ☑ No
Is the patient under a surgical Global Period? ☐ Yes ☐ No
CPT Code:
Specialty Site Name (if different from above):

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

Important Notes

Please include the front & back copy of the patient insurance card.
This verification of benefits is not a guarantee of payment by the payor.

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 the sole purpose of claim support.

Physician or Authorized Signature: John Smith _____ **Date** 9/28/2024

This verification of benefits is not a guarantee of payment by the payor, but is deemed as current coverage information as relayed by the payor. This verification cannot take the place of written policy guidance from the payor. Check local coverage guidelines for documentation requirements for insurance claims submissions