



**INSURANCE VERIFICATION REQUEST**  
**FAX: (800) 946-5550 PHONE: (800) 533-2018**  
**PORTAL UPLOAD: [www.provider.rmbbhealth.com](http://www.provider.rmbbhealth.com)**

Sales Rep Name/Email \_\_\_\_\_  
Distributor Company Name \_\_\_\_\_  
Additional Sales Contact(s) \_\_\_\_\_

IVR Support provided by

**RMBB Health**  
A Specialized Market Access Company

**Patient Information**

First \_\_\_\_\_  
Last \_\_\_\_\_  
DOB \_\_\_\_\_  
Phone \_\_\_\_\_  
Address \_\_\_\_\_

Primary Insurance \_\_\_\_\_  
ID # \_\_\_\_\_  
Phone # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_  
ID # \_\_\_\_\_  
Phone # \_\_\_\_\_

\*Please provide copy of card(s) if available

Medicare does not provide separate reimbursement for products when patient is receiving inpatient care or is covered by Medicare Part A benefits.  
Is the patient currently under Part A stay in any other facility? \_\_\_\_\_  
Is the patient under a surgical global period? If yes, CPT code(s) \_\_\_\_\_ Dates of procedure/surgery: \_\_\_\_\_

**Place Of Service** OFFICE(11) HOPD(22) ASC(24) Nursing Home(32) OTHER \_\_\_\_\_  
PLEASE CHECK HERE IF BILLING POS IS DIFFERENT THAN TREATING POS (Mobile Wound Care)

**Provider**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
NPI \_\_\_\_\_  
Tax ID \_\_\_\_\_  
PTAN \_\_\_\_\_  
Contact \_\_\_\_\_

**Facility**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
NPI \_\_\_\_\_  
Tax ID \_\_\_\_\_  
PTAN \_\_\_\_\_  
Contact \_\_\_\_\_

**Treatment Information**

Wound Type: Diabetic Foot Venous Leg Ulcer Pressure Ulcer Chronic Non-Pressure Ulcer  
Other: \_\_\_\_\_ Wound Size(s): \_\_\_\_\_

ICD-10 Diagnosis Code(s): \_\_\_\_\_

Product HCPCS: Q4204 (XWRAP)

Date of Application: \_\_\_\_\_ Anticipated # of Applications: \_\_\_\_\_ Anticipated Graft Size \_\_\_\_\_

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

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.

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.

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

ALL SECTIONS OF THIS FORM MUST BE COMPLETED. ANY MISSING INFORMATION COULD DELAY THE PROCESSING TIME OF THE REQUEST. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM, PLEASE CONTACT THE CLIENT SERVICES TEAM.

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's evidence of coverage. The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify the sender immediately and shall destroy all information received.