PATIENT INSURANCE VERIFICATION REQUEST

Fax: 855-632-2760 Hotline Email: IVR@biowound.com

Territory:

Sales Rep: Rep Email:

New Request: ☐ Re-Verification: ☐ Additional Applications: ☐ New Insurance: ☐

FACILITY AND PHYSICIAN INFORMATION

Physician Name:	
Physician Specialty:	
Facility Name:	
Facility Address:	
City, State, Zip:	
Contact Name:	
Contact Email:	

	Physician	Facility
NPI:		
Tax ID:		
PTAN (Medicare #):		
Medicaid #:		
Phone #:		
Fax #:		

Physician Office (POS 11) ☐ Hospital Inpatient (POS 21) ☐ Ambulatory Surgical Center (POS 24) ☐

Hospital Outpatient (POS 22) ☐ Nursing Facility (POS 32) ☐ Assisted Living (POS 13) ☐

Critical Access Hospital ☐ Home (POS 12) ☐ Other:

PATIENT INFORMATION

Patient Name:	Is the patient currently in a Skilled Nursing Facility? Yes ☐ No ☐
Patient Date of Birth:	Number of Days in SNF?
Patient Address:	Is the patient currently in a surgical global period? Yes ☐ No ☐

INSURANCE INFORMATION

Primary	Secondary
Payer Name:	Payer Name:
Policy #:	Policy #:
Payer Phone #:	Payer Phone #:

If the payer requires prior authorization for pre-determination for BioWound Solutions product applications, would you like assistance?

Yes ☐ No ☐ If yes, please attach a minimum of four weeks of clinical notes

Please fax in patient's face sheet and insurance cards. If Commercial/Medicare Advantage/Medicaid/Managed Medicaid, please fax in 4 weeks of chart notes.

PRODUCT

Q4161 Bio-Connekt	Q4205 Membrane Wrap	Q4290 Membrane Wrap - Hydro	Q4238 Derm-Maxx	Q4239 Amnio-maxx	Q4266 NeoStim SL	Q4267 NeoStim DL	Q4265 NeoStim TL
☐	☐	☐	☐	☐	☐	☐	☐

Wound Info

Wound Type

Diabetic Foot Ulcer	☐
Venous Leg Ulcer	☐
Chronic Ulcer	☐
Dehisced Surgical Wound	☐
Mohs Surgical Wound	☐
Other:	☐

ICD-10 Codes

Primary:	
Secondary:	

Wound Description

Wound Location:	
Wound Duration:	
Post Debridement Total Size of Ulcers (cm^2):	

Previously Used Therapies:

Co-Morbities:

AUTHORIZED HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED

I certify that I have obtained a valid authorization under applicable law from the patient listed on this form (a) permitting me to release the patientas protected health information (PHI), to EMP and its contractors to research insurance coverage regarding BioWound Solution's products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to EMP and its contractors for the purposes of determining benefit coverage.

Authorized Signature: Date:

Disclaimer: EMP Reimbursement Group offers insurance verification as an information service only. Information gathered during the requested research will be provided by the insurer or third -party pater. Results of this research are not a guarantee of coverage or reimbursement in the future. EMP Reimbursement Group disclaims liability for payment of any claims, benefits or costs.

Advantage Hotline Reimbursement, please email/fax results to 855-632-2760/IVR@biowound.com and to the requesting provider, thank you!!!!!