SERVICED BY;
ACZ & Associates, LLC
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ACZ DISTRIBUTION
NEVADA, USA

INSURANCE VERIFICATION REQUEST

☐ Membrane Wrap Q4205 ☐ Amnio- maxx Q4239 ☐ Revoshield Q4289 ☐ Derm-maxx Q4238 ☐ Membrane Wrap hydr Q4290

REPRESENTATIVE NAME: _____ ISO IF APPLICABLE: _____

ADDITIONAL EMAILS FOR NOTIFICATION (REQUIRES BAA): _____

TREATING PHYSICIAN AND FACILITY DEMOGRAPHIC INFORMATION

		PHYSICIAN	FACILITY
PHYSICIAN NAME: _____	NPI:		
PHYSICIAN SPECIALTY: _____	TAX ID:		
FACILITY NAME: _____	PTAN:		
FACILITY ADDRESS: _____	MEDICAID #:		
CITY, STATE, ZIP: _____	PHONE #:		
CONTACT NAME: _____	FAX #:		
CONTACT PH/EMAIL: _____	MANAGEMENT CO:		

PLACE OF SERVICE WHERE PATIENT IS BEING SEEN:

☐ PHYSICIAN OFFICE (POS 11) ☐ HOSPITAL OUTPATIENT (POS22) ☐ SURGERY CENTER (POS 24) ☐ HOME (POS12)
☐ NURSING CARE FACILITY (POS 32) ☐ OTHER (PLEASE SPECIFY):_____

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT NAME: _____ PATIENT DOB: _____

PATIENT ADDRESS: _____ CITY, STATE, ZIP: _____

PATIENT PHONE: _____ PATIENT FAX/EMAIL: _____

PATIENT CAREGIVER INFO: _____

PRIMARY	SECONDARY
INSURANCE NAME: _____	INSURANCE NAME: _____
POLICY NUMBER: _____	POLICY NUMBER: _____
PAYER PHONE: _____	PAYER PHONE: _____
PROVIDER STATUS: ☐ IN-NETWORK ☐ OUT-OF-NETWORK	PROVIDER STATUS: ☐ IN-NETWORK ☐ OUT-OF-NETWORK

DO WE HAVE YOUR PERMISSION TO INITIATE AND FOLLOW UP ON PRIOR AUTHORIZATION? ☐ YES ☐ NO

IS THE PATIENT CURRENTLY IN HOSPICE? ☐ YES ☐ NO

IS THE PATIENT IN A FACILITY UNDER PART A STAY? ☐ YES ☐ NO IF YES, PART B SERVICES CANNOT BE BILLED.

IS THE PATIENT CURRENTLY UNDER A POST-OP GLOBAL SURGICAL PERIOD? ☐ YES ☐ NO

IF YES, PLEASE LIST CPT CODE(S) OF PREVIOUS SURGERY: _____ SURGERY DATE: _____

LOCATION OF WOUND:

LEGS/ARMS/TRUNK ≤ 100 SQ CM ☐ 15271/15272 LEGS/ARMSTRUNK ≥ 100 SQ CM ☐ 15273/15274

FEET/HANDS/HEAD ≤ 100 SQ CM ☐ 15275/15276 FEET/HANDS/HEAD ≥ 100 SQ CM ☐ 15277/15278

ICD-10 CODES:

_____

TOTAL WOUND SIZE AND / OR MEDICAL HISTORY:

_____

_____