CENTURION
THERAPEUTICS

Required information indicated by *

☐ New Wound ☐ Additional Application ☐ Re-verification ☐ New Insurance

INSURANCE VERIFICATION
EMAIL TO : hotline@advantagerma.com
FAX TO: 855-729-5758

Patient and Insurance Information

*Patient Name: *DOB: ☐ Male ☐ Female

Address: City: State: Zip:

Home Phone #: Mobile #:

*Is this patient currently in a skilled facility or nursing home? ☐ Yes ☐ No

If YES, how many days has the patient been admitted to the skilled nursing facility or nursing home?

Primary Insurance: Secondary Insurance:

Payer Phone #: Payer Phone:

Policy Number: Policy Number:

Subscriber Name: Subscriber Name:

Provider and Facility Information

*Provider Name: Specialty: PTAN #:

Provider ID #s: NPI: Tax ID: Medicaid Provider #

*Facility Name:

Address: City: State: Zip:

Facility ID #s: NPI: Tax ID: PTAN #:

*Facility Contact: Phone #: Fax #:

Email Address:

*Treatment Setting: ☐ Hospital Outpatient Wound Dept/Clinic (HOPD) (POS-22) ☐ Provider's Office (POS-11)
☐ Home (POS-12) ☐ ALF (POS-13) ☐ SNF (POS-31) ☐ Nursing (POS-32)

Coding and Billing

☐ AmnioBand Q4151
☐ Allopatch Q4128

Primary Secondary Tertiary

Known Conditions:

Anticipated Treatment Start Date: Frequency: Number of Applications:

If the payer requires prior authorization for pre-determination for product applications, would you like assistance?
☐ Yes ☐ No If yes, please attach a minimum of four weeks of clinical notes

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 patient's protected health information (PHI), to EMP and its contractors to research insurance coverage regarding [insert] 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.

Provider Signature:_____ Date:_____ Sales Representative:_____
Please fax this form along with a copy of the front and back of the patient's insurance card. Email: