StimLabs Authorization Request Form

NON-HOPD WOUND

Fax this form to 470-616-2397

Sales Representative Name_____

Select the StimLabs product:

☐ Relese™ Q4257 ☐ Corplex® Q4232 ☐ Revita® Q4180

Patient Information		Physician and Facility Information		
Today's Date:		Physician Name:		
Patient Name:		Name of Practice:		
Patient Insurance ID Number:		NPI:	Tax ID:	
Patient Date of Birth:		Contact Name:		
Gender (M/F):		Contact Email Address:		
Street Address:		Contact Phone Number:		
City:		Contact Fax Number:		
State:	Zip:	Office Street Address:		
Phone Number:		City:	State:	Zip:

Place of Service

☐ Physician Office ☐ Other_____

Insurance Information

Primary Insurance:	Secondary Insurance:
Payer Phone Number:	Payer Phone Number:
Policy Number:	Policy Number:
Subscriber Name:	Subscriber Name:

Procedure Information

Scheduled date of service (month/day/year)	Procedure code(s) (please circle)	Diagnosis code(s)
	15271 / 15272 15275 / 15276 15273 / 15274 15277 / 15278	

Answer all the following questions:

Where on/in the patient's body will the product be used? _____

What is the size of the wound in square centimeters? _____

What past treatments have failed for this patient? _____

Has the patient been diagnosed with Diabetes? ☐ Yes ☐ No Has the patient failed 4 weeks of treatment? ☐ Yes ☐ No

Is this the patient's initial treatment? ☐ Yes ☐ No Is the patient in a skilled nursing facility? ☐ Yes ☐ No

Is the Provider willing to perform a Peer-to-Peer if needed? ☐ Yes ☐ No

If yes, please provide best contact number_____

REQUIRED CLINICAL DOCUMENATION: PLEASE ATTACH ALL RELEVANT CLINICAL SUPPORTING DOCUMENTATION.

I confirm the medical necessity as defined herein. I further confirm that the information above is accurate and true, and that the documentation supporting this information is available for review if requested by the health insurer, or if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. I certify that I have received the necessary patient authorization to release the medical and/or patient information to StimLabs and consent to the jurisdiction of the Georgia state and federal courts relating to services provided herein.

Authorized Signature:	Date: