Patient Insurance Support Form

Please fax completed form to toll-free HIPPA compliant fax: 223.336.4751
Or email to Reimbursement@AdvancedSolution.Health

Sales Rep _____

Facility Information

Place of Service: ☐ Office ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Other

Facility Name:
Address:
Contact Name:
Phone:
Fax:

Medicare Admin Contractor:
NPI:
TIN:
PTAN:

Physician Information

Physician Name:
Address:
Phone:

Fax:
NPI:
TIN:

Patient Information

Patient Name:
Address: [City / State / Zip]
Date of Birth:

Phone:
OK to Contact Patient?: ☐ Yes ☐ No

Insurance Information

Primary Insurance
Subscriber Name:
Policy Number:
Subscriber DOB:
Type of Plan: ☐ HMO ☐ PPO ☐ Other
Insurance Phone Number:
Does Provider Participate with Network?: ☐ Yes ☐ No
Not Sure (Please verify)

Secondary Insurance
Subscriber Name:
Policy Number:
Subscriber DOB:
Type of Plan: ☐ HMO ☐ PPO ☐ Other
Insurance Phone Number:
Does Provider Participate with Network?: ☐ Yes ☐ No
Not Sure (Please verify)

Wound Information

Wound Type: ☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐ Pressure Ulcer ☐ Traumatic Burns ☐ Radiation Burns ☐ Necrotizing Faciitis ☐ Dehisced Surgical Wound ☐ Other
Wound Size(s):
Application CPT(s):
Date of Procedure:
ICD-10 Diagnosis Code(s):
Product Information: ☐ CompleteAA ☐ Membrane Wrap Hydro ☐ Membrane Wrap ☐ WoundPlus ☐ CompleteFT ☐ Other:

Additional Information

Is the patient currently residing in SNF? ☐ Yes ☐ No
Is the patient under a surgical Global Period? ☐ Yes ☐ No
CPT Code:
Specialty Site Name (if different from above):

If Prior Authorization is Required, check here to allow us to work with payer on your behalf. ☐ **Please attach a copy of the patient's clinical records**

Important Notes

Please include the front & back copy of the patient insurance card.
This verification of benefits is not a guarantee of payment by the payor.

Physician Agreement

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 the sole purpose of claim support.

Physician or Authorized Signature: _____ **Date**_____

This verification of benefits is not a guarantee of payment by the payor, but is deemed as current coverage information as relayed by the payor. This verification cannot take the place of written policy guidance from the payor. Check local coverage guidelines for documentation requirements for insurance claims submissions