**Sales Rep Contact Information:Facility Return Contact Information: Insurance Verification Request (IVR) Form**

Name: Name: Fax Completed Form to: 855-925-6544

Email: Email: Email: reimbursement@stabilitybio.com

Phone: Phone:

| **Facility Information** | | | | |
| --- | --- | --- | --- | --- |
| Facility Address: | | | | Tax ID: |
| Physician Name: | Practice Name: | | | Office Contact Name: |
| Physician PTAN: | Practice PTAN: | | | Office Contact Email: |
| Physician NPI: | Practice NPI: | | | Office Contact Fax: |
|  | | | | |
| **Patient Information** | | | | |
| Patient Name: | | Cardholder Name/Relationship: | | Patient DOB: |
| Primary Insurance: | | Group #: | | Member ID: |
| Secondary Insurance: | | Group #: | | Member ID: |
| Copy of Front and Back of Insurance Card Attached: **Yes or No** | | | | |
| Place of Service (Circle One): **(11)** Office **(12)** Home **(13)** Assisted Living **(22)** HOPD **(24)** Ambulatory Surgery Center **(32)** Nursing Facility | | | | |
| Is the patient currently residing in a Nursing Home OR Skilled Nursing Facility: **Yes or No** | | | | If yes, has it been over 100 days? **Yes or No** |
| Is this patient currently under a post-op period? **Yes or No** | | | | |
| **If yes, please list CPT code(s) of previous surgery:** | | | | **Surgery Date:** |
|  | | | | |
| **Procedure Information** | | | | |
| Procedure Date: | | | Wound Size: L\_\_\_\_\_\_\_\_\_\_\_\_ W\_\_\_\_\_\_\_\_\_\_\_\_ D\_\_\_\_\_\_\_\_\_\_\_\_ Total\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Wound Location: | | | Size of Graft Requested: | |
| Graft Requested: AmnioCore (Q4227) Amnio Tri-Core (Q4295) Amnio Quad-Core (Q4294) AmnioCore Pro (Q4298) AmnioCore Pro+ (Q4299) AmnioAmp (Q4250) Dermacyte (Q4248) | | | | |
| ICD-110 | | CPT | | HCPCS (when applicable) |
| 1) | | 1) | | 1) |
| 2) | | 2) | | 2) |
| 3) | | 3) | | 3) |
| 4) | | 4) | | 4) |
|  | | | | |
| **Healthcare Provider Signature:**  By signing below, I certify that I have obtained a valid authorization from the patient listed on this form permitting me to release the patient’s protected health information (PHI) to the Stability Biologics Reimbursement Hotline Services, Stability Biologics, LLC, its contractors, and the patient’s health insurance company as necessary to research insurance coverage and payment information to determine benefits related to AmnioCore products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge.  **For typed signatures below:** I agree that this typed signature has the same validity and meaning as my handwritten signature.  **HCP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Disclaimer: The Stability Biologics Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Stability Biologics disclaims liability for payment of any claims, benefits or costs. | | | | |

The Stability Biologics® AmnioCore Product Line is regulated by the FDA under 21 CFR Part 1271

Human Cells, Tissues and Cellular and Tissue-Based Products (HCT/Ps). AmnioCore is processed by

and donor eligibility determined by Stability Biologics®. Stability Biologics® is registered with the FDA for tissue processing and accredited by the American Association of Tissue Banks (AATB).

MKT-104 Rev C Effective 01022024

**Questions? Contact the Stability Biologics Reimbursement Hotline at: Email: reimbursement@stabilitybio.com**

**Phone: (855) 925-6154**

**Fax: (855) 925-6544**

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