ExtremityCare®
in partnership with ParametricsMedical

RESTORIGIN™
Insurance Verification Request

Fax Form to 1.800.640.2060 or email to IVR@extremitycare.com
Questions? Call: 1.888.694.6694

Required information indicated by *

❑ New Application ❑ Additional Application
❑ Re-verification ❑ New Insurance

Place of Service:
❑ Physician Office/Clinic (POS11) ❑ Patient Home (POS12) ❑ Assisted Living Facility (POS13)
❑ Nursing Facility (POS32) ❑ Skilled Nursing Facility (POS31) ❑ Other

Restorigin™ Q4191
Product Requested

❑ 12mm Disc	❑ 2x3cm	❑ 5x5cm
❑ 16mm Disc	❑ 2x4cm	❑ 4x8cm
❑ 1.5x1.5cm	❑ 4x4cm	
❑ 2x2cm	❑ 4x6cm	

PATIENT AND PAYER INFORMATION

*Patient Name: *DOB: ❑ Male ❑ Female

Address: City: State: Zip:

*Is this patient currently in a skilled nursing 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:

PROVIDER AND FACILITY INFORMATION

*Provider Name:

*Provider ID #'s NPI: Tax ID# Medicare Provider #

*Facility Name:

Address: City: State: Zip:

*Facility ID #'s NPI: Tax ID#

*Facility Contact: Phone#: Fax#:

*Facility Contact Email:

CODING AND BILLING

❑ Q4191 Restorigin™

CPT:

Legs/Arms/Trunk ≤ 100 sq cm	❑ 15271/15272	Legs/Arms/Trunk ≥ 100 sq cm	❑ 15273/15274
Feet/Hands/Head ≤ 100 sq cm	❑ 15275/15276	Feet/Hands/Head ≥ 100 sq cm	❑ 15277/15278

Anticipated Application Date: _____ Number of Anticipated Applications: _____

Wound Information & Diagnosis Code(s): ***Provide the ICD-10-CM Code(s) for the treatment condition below:***

❑ Diabetic Ulcer (Code Diabetes **and** Ulcer Locations Separately), 2 codes must be present on claim: _____, _____
❑ Venous Ulcer (Code Venous **and** Ulcer Locations Separately), 2 codes must be present on claim: _____, _____
❑ Surgical Dehiscence: _____, _____ ❑ Other: _____, _____
❑ Pressure Ulcer: _____, _____ ❑ Trauma Wounds: _____, _____

Please fax this form along with a copy of the front and back of the patient's insurance card to 1.800.640.2060

Disclaimer: Extremity Care LLC offers insurance verification as an information service only. Information gathered during the requested research will be provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement in the future. Extremity Care LLC disclaim liability for payment of any claims, benefits, or costs.

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