INFUGEM Support™

How to get started with INFUGEM Support™

Please complete the Enrollment Form in its entirety.

1 Be Sure to Complete All Required Sections

2 You Must Sign and Date the Form:

Make certain the patient (or patient representative) reads the Patient Enrollment Authorization section at the bottom of the form, then prints, dates, and signs his/her name.

IMPORTANT: Patient authorization or signature is required.

3 Submit the Completed INFUGEM Support™ Forms by Either:

Email: BV@thepinnaclehealthgroup.com
Fax: 1-215-369-9198
Call toll-free: 1-877-INFUGEM (1-877-463-8436)

☑ Claim Appeal (please see item 6 on next page)

This INFUGEM Support™ Enrollment Form can also be used in the event the insurance company denies coverage or provides inappropriate reimbursement for any procedure. To do this, check the appropriate boxes on the form and attach supporting documentation:

- Copy of the Remittance Advice; indicate the code(s) or service(s) being appealed
- Medical documentation related to the appeal (medical records, operative report, etc)
- Copy of the claim form submitted to insurance company
- Any additional documentation that will assist in the review

What to expect after enrollment

- If you request a benefits verification (BV),* INFUGEM Support™ will contact you by email within 24 to 48 hours upon receipt of all required information
- INFUGEM Support™ is available to help you with the appeals and denials process and will also confirm if you would like to appeal the denial
- INFUGEM Support™ can help with billing and coding. Even if you have a simple question about coding, call us and talk to one of our certified coding specialists

Have a billing and coding question?

Call a certified coding specialist at 1-877-INFUGEM (1-877-463-8436), Monday to Friday, 8:30 AM to 6:00 PM EST

CPT=Current Procedural Terminology; HCPCS=Healthcare Common Procedure Coding System; ICD-10-CM=International Classification of Disease, Tenth Revision, Clinical Modification.

*Verification of benefits is not a guarantee of payment and does not take the place of written policy information.

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Healthcare providers may be required to precertify services with the insurance company. If you need assistance obtaining precertification for your patient, please complete this form and fax it together with a copy of the patient's insurance card and the signed Patient Enrollment Authorization to INFUGEM Support™ at 1-215-369-9198.

All information is required, item 6 is optional.

1 Patient Information (Required)

Name _____

Address _____

City _____ State _____ ZIP Code _____

Date of Birth ___/___/_____ Email _____ Phone Number___-___-_____

2 Patient Insurance Information (Required)

Primary

Name of Insurance _____

Policy Holder Name _____ Policy Holder Date of Birth ___/___/_____

Member/Contract/Plan ID _____ Group Number _____

Provider Services/Insurance _____

Phone Number ___-___-_____

Prior Authorization Number _____

Secondary

Name of Insurance _____

Policy Holder Name _____ Policy Holder Date of Birth ___/___/_____

Member/Contract/Plan ID _____ Group Number _____

Provider Services/Insurance _____

Phone Number ___-___-_____

Prior Authorization Number _____

3 Procedure (Required)

ICD-10 Code _____ Other ICD-10 Code _____

HCPCS Code (J9199) _____ Other HCPCS/CPT _____

CPT Code(s): 96413; 96415; 96416; 96417 _____ Date of Procedure _____

Point of Service: ○ (11) Physician Office/Freestanding ○ (21) Inpatient Hospital ○ (22) Outpatient Hospital

4 Physician/Healthcare Provider Information (Required)

Name _____ Tax ID Number _____

NPI Number _____ Provider Number _____

Address _____ City _____ State _____ ZIP Code _____

Phone Number ___-___-_____ Fax ___-___-_____

Office Contact Name _____ Office Contact Direct Number ___-___-_____

Office Contact Email _____

5 Patient Enrollment Authorization (Required)

I, _____, authorize my healthcare provider and health insurance plan to disclose to The Pinnacle Health Group and/or their representatives information about my medical condition, treatment, and insurance coverage (eg, my diagnosis, medical history, and insurance coverage limitations) as needed to authorize benefits for my procedure and determine if this procedure may be covered under the terms of my health insurance policy. Further, I support appeals and consent to being contacted by The Pinnacle Health Group with respect to supporting the coverage for this procedure. I understand that I may refuse to sign this authorization and can revoke this authorization at any time, except to the extent that The Pinnacle Health Group has taken action in reliance on it by mailing a written request to revoke this authorization to my insurance provider. I have read and understand this consent statement.

X _____ ___/___/_____

Patient Signature Date (MM/DD/YYYY)

6 Claim Appeal (Optional)

☐ Copy of the Remittance Advice; indicate the code(s) or service(s) being appealed

☐ Medical documentation related to the appeal (medical records, operative report, etc)

☐ Copy of the claim form submitted to insurance company

☐ Additional documentation that will assist in the review

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PM-US-INF-0127 12/2019

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