

# 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.

# INFUGEM Support™

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	Secondary
Name of Insurance _____	Name of Insurance _____
Policy Holder Name _____ Policy Holder Date of Birth ____/____/____	Policy Holder Name _____ Policy Holder Date of Birth ____/____/____
Member/Contract/Plan ID _____ Group Number _____	Member/Contract/Plan ID _____ Group Number _____
Provider Services/Insurance _____	Provider Services/Insurance _____
Phone Number ____-____-____	Phone Number ____-____-____
Prior Authorization Number _____	Prior Authorization Number _____

## 3 Procedure (Required)

ICD-10 Code \_\_\_\_\_ Other ICD-10 Code \_\_\_\_\_  
HCPCS Code (J9198) \_\_\_\_\_ 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.



\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date (MM/DD/YYYY)

## 6 Claim Appeal (Optional)

- |                                                                                                               |                                                                                  |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| <input type="checkbox"/> Copy of the Remittance Advice; indicate the code(s) or service(s) being appealed     | <input type="checkbox"/> Copy of the claim form submitted to insurance company   |
| <input type="checkbox"/> Medical documentation related to the appeal (medical records, operative report, etc) | <input type="checkbox"/> Additional documentation that will assist in the review |



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**INFUGEM™**  
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