SERVICED BY;
ProMed Health Plus
1100 Ludlow Street
Philadelphia, PA 19107
o. 267-235-1092
www.promedhealthplus.com

ProMed Health Plus
Philadelphia, USA

Sales Representative: _____

INSURANCE VERIFICATION REQUEST

☐ Membrane Wrap Q4205 ☐ Amnio-Maxx Q4239 ☐ Helicoll Q4164 ☐ Derm-Maxx Q4238 ☐ Membrane Wrap Hydro Q4290 ☐ ACApatch Q4325 ☐ caregraFT Q4322 ☐ alloPLY Q4323

☐ Activate Matrix Q4301 ☐ Emerge Matrix Q4297 ☐ NeoStim TL Q4265 ☐ AmnioAMP-MP Q4250 ☐ Xcell Amnio Matrix Q4280 ☐ DermaBind FM Q4313 ☐ DermaBind TL Q4225 ☐ Revoshield+ Q4289

☐ Restorgin Q4191

TREATING PHYSICIAN AND FACILITY DEMOGRAPHIC INFORMATION

PHYSICIAN NAME: William Chandler
PHYSICIAN SPECIALTY: _____
FACILITY NAME: _____
FACILITY ADDRESS: _____
CITY, STATE, ZIP: _____
CONTACT NAME: _____
CONTACT PH/EMAIL: vastyle2010@gmail.com

	PHYSICIAN	FACILITY
NPI:		
TAX ID:		
PTAN:		
MEDICAID #:		
PHONE #:		
FAX #:		
MANAGEMENT CO:		

PLACE OF SERVICE WHERE PATIENT IS BEING SEEN:

☐ PHYSICIAN OFFICE (POS 11) ☐ HOSPITAL OUTPATIENT (POS22) ☐ SURGERY CENTER (POS 24) ☐ HOME (POS12)
☐ NURSING CARE FACILITY (POS 32) ☐ OTHER (PLEASE SPECIFY):_____

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

PATIENT NAME: _____ PATIENT DOB: 1998-10-16
PATIENT ADDRESS: 31 St. James Ave. CITY, STATE, ZIP: Boston, Massachusetts 02116
PATIENT PHONE: +16178223135 PATIENT FAX/EMAIL: _____
PATIENT CAREGIVER INFO: _____

PRIMARY
INSURANCE NAME: Blue Cross Blue Shield
POLICY NUMBER: 8765490653214
PAYER PHONE: _____
PROVIDER STATUS: ☐ IN-NETWORK ☐ OUT-OF-NETWORK

SECONDARY
INSURANCE NAME: MetLife Health Insurance
POLICY NUMBER: 0187364927465629290
PAYER PHONE: _____
PROVIDER STATUS: ☐ IN-NETWORK ☐ OUT-OF-NETWORK

DO WE HAVE YOUR PERMISSION TO INITIATE AND FOLLOW UP ON PRIOR AUTHORIZATION? ☐ YES ☐ NO
IS THE PATIENT CURRENTLY IN HOSPICE? ☐ YES ☐ NO
IS THE PATIENT IN A FACILITY UNDER PART A STAY? ☐ YES ☐ NO IF YES, PART B SERVICES CANNOT BE BILLED.
IS THE PATIENT CURRENTLY UNDER A POST-OP GLOBAL SURGICAL PERIOD? ☐ YES ☐ NO
IF YES, PLEASE LIST CPT CODE(S) OF PREVIOUS SURGERY: _____ SURGERY DATE: _____

LOCATION OF WOUND:

LEGS/ARMS/TRUNK ≤ 100 SQ CM ☐ 15271/15272
LEGS/ARMSTRUNK ≥ 100 SQ CM ☐ 15273/15274
FEET/HANDS/HEAD ≤ 100 SQ CM ☐ 15275/15276
FEET/HANDS/HEAD ≥ 100 SQ CM ☐ 15277/15278

ICD-10 CODES:

_____

TOTAL WOUND SIZE AND / OR MEDICAL HISTORY:

_____

PHYSICIAN SIGNATURE: _____