AmnioRepair® Allograft

Insurance Verification Request Form

Phone: (855) 200-2760
Fax: (855) 200-2761

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Your progress. Our promise.®

PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

Patient Name:	Date of Birth:	Social Security Number:	☐ Female ☐ Male
Address:		City: State:	Zip Code:
Primary Insurance:		**Secondary Insurance:**	
Payer Phone Number:		Payer Phone Number:	
Policy Number:		Policy Number:	
Group Number:		Group Number:	

☐ If the patient has tertiary insurance, please check this box and fill out an additional Insurance Verification Request Form.

TREATING PROVIDER AND FACILITY INFORMATION

Provider Name:		Specialty:	
Provider NPI or Tax ID Number:		Is Provider In Network with Payer?	☐ Yes ☐ No ☐ Unknown
Medicaid Provider Number:		☐ NA	
Office Contact:		Phone Number:	Fax Number:
Site of Service:	☐ Hospital-Based Outpatient Wound Department (HOPD)		☐ Physician Office
	☐ Ambulatory Surgery Center (ASC)		☐ Skilled Nursing Facility (SNF)
	☐ Inpatient Hospital, Acute		☐ Long-Term Care Hospital (LTCH)
Facility Name:			
Address:		City: State:	Zip Code:
Facility NPI or Tax ID Number:		Is Facility In-Network with Payer?	☐ Yes ☐ No ☐ Unknown
Medicaid Provider Number:		☐ NA	

PRESCRIPTION INFORMATION (ICD-10-CM Diagnosis codes require a greater level of specificity including an exact anatomical location, etiologies, comorbidities and complications to demonstrate severity of illness.)

Product: ☐ Q4235 AmnioRepair® Allograft

PATIENT ICD-10-CM DIAGNOSIS CODES Only (see note above)	Primary: Secondary: Tertiary: ***Note: Only diagnoses to be treated with AmnioRepair should be provided. Please rank the diagnosis codes in the order in which they will be billed.***
Treatment Codes: **Patient CPT® Code(s)/ HCPCS (Healthcare Common Procedure Coding System) Code(s) Application Code(s)**	**For Wounds on the Trunks, Arms, and/or Legs** ☐ 15271/C5271 ☐ 15272/C5272 ☐ 15273/C5273 ☐ 15274/C5274 **For Wounds on the Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, and/or Multiple Digits** ☐ 15275/C5275 ☐ 15276/C5276 ☐ 15277/C5277 ☐ 15278/C5278 *Note: Check boxes from both rows for patients who have multiple wound locations.*

Anticipated treatment start date: _____ Number of applications: _____ Frequency: _____

PROVIDER ATTESTATION

By my signature below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that the Asembia Specialty Pharmacy Network reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN and Zimmer Biomet as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN and Zimmer Biomet to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

Signature of Treating Provider: _____ **Date:** _____

Please fax this form along with a copy of the front and back of the patient's insurance card to (855) 200-2761

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Questions? Please call the Zimmer Biomet Reimbursement Hotline at: 1-866-946-0444

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