# INSURANCE VERIFICATION REQUEST

**FAX: (800) 946-5550 PHONE: (800) 533-2018**

**PORTAL UPLOAD: www.provider.rmbbhealth.com**

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Distributor Company Name: Group Manager: Brent Kish

Additional Sales Contact(s): Brent Kish: bkish@dermxbiologics.com

IVR Support provided by RMBB Health — A Specialized Market Access Company

## Patient Information

First _____

Last _____

DOB _____

Phone _____

Address _____

Primary Insurance _____

ID # _____

Phone # _____

Secondary Insurance _____

ID # _____

Phone # _____

*Please provide copy of card(s) if available

Medicare does not provide separate reimbursement for products when patient is receiving inpatient care or is covered by Medicare Part A benefits.

Is the patient currently under Part A stay in any other facility? ☐

Is the patient under a surgical global period? If yes, CPT code(s) _____ Dates of procedure/surgery: _____

**Place Of Service** OFFICE(11) HOPD(22) ASC(24) Nursing Home(32) OTHER _____

PLEASE CHECK HERE IF BILLING POS IS DIFFERENT THAN TREATING POS (Mobile Wound Care) ☐

## Provider

Name _____

Address _____

City/State/Zip _____

Phone _____

Fax _____

NPI _____

Tax ID _____

PTAN _____

Contact _____

## Facility

Name _____

Address _____

City/State/Zip _____

Phone _____

Fax _____

NPI _____

Tax ID _____

PTAN _____

Contact _____

## Treatment Information

Wound Type: Diabetic Foot Ulcer Venous Leg Ulcer Pressure Ulcer Burns Dehisced Surgical Wound

Necrotizing Faciitis Other: _____ Wound Size(s): _____

ICD-10 Diagnosis Code(s): _____

Product HCPCS: Q4204 (XWRAP)

Date of Application: _____ Anticipated # of Applications _____ Anticipated Graft Size _____

Application CPT(s): 15271 15272 15273 15274 15275 15276 15277 15278

If Prior Authorization is required, check here to allow us to work with the payer on your behalf. ☐

Please attach a copy of the patient's clinical records.

By signing below, I certify that I have received the necessary patient authorization to release the medical and/or other patient information referenced on the form relating to the above referenced patient. This information is for verifying insurance coverage, seeking reimbursement, and sole purpose of claim support.

**Authorized Signature:** _____ **Date:** _____

ALL SECTIONS OF THIS FORM MUST BE COMPLETED. ANY MISSING INFORMATION COULD DELAY THE PROCESSING TIME OF THE REQUEST. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM, PLEASE CONTACT THE CLIENT SERVICES TEAM.

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's evidence of coverage.