PATIENT ELIGIBILITY, BENEFITS AND PRIOR AUTHORIZATION REQUEST FORM

Questions? reimbursement@venturemedical1.com FAX TO: (833-608-2649)

PRODUCT AND REPRESENTATIVE INFORMATION

Artacent Wound	Vendaje AC	Biovance	Progenamatrix	Grafix PL Prime	Revo Shield	Aurix PRP
Q4169	Q4279	Q4154	Q4222	Q4133	Q4289	G0465

REPRESENTATIVE NAME: ____________________ REPRESENTATIVE EMAIL: ____________________

SALES AGENCY NAME: ____________________ SALES AGENCY EMAIL: ____________________

ADDITIONAL EMAILS FOR NOTIFICATION: ____________________

TREATING PHYSICIAN AND FACILITY DEMOGRAPHIC INFORMATION

			PHYSICIAN	FACILITY
PHYSICIAN NAME:		NPI:		
PHYSICIAN SPECIALTY:		TAX ID:		
FACILITY NAME:		PTAN:		
FACILITY ADDRESS:		MEDICAID #:		
CITY, STATE, ZIP:		PHONE #:		
CONTACT NAME:		FAX #:		
CONTACT PH/EMAIL:		MANAGEMENT CO:		

PLACE OF SERVICE WHERE PATIENT IS BEING SEEN:

☐ PHYSICIAN OFFICE (POS 11) ☐ HOSPITAL OUTPATIENT (POS 22) ☐ SURGERY CENTER (POS 24) ☐ HOME (POS 12)

☐ OTHER (PLEASE SPECIFY): ____________________

PATIENT DEMOGRAPHIC AND INSURANCE INFORMATION

***PLEASE ATTACH PATIENT FACE SHEET, COPY OF INSURANCE CARD(S) AND PROGRESS NOTES PERTINENT TO THE CONDITION. ***

PATIENT NAME: ____________________ PATIENT DOB: ____________________

PATIENT ADDRESS: ____________________ CITY, STATE, ZIP: ____________________

PATIENT PHONE: ____________________ PATIENT FAX/EMAIL: ____________________

PATIENT CAREGIVER INFO: ____________________

PATIENT GENDER: MALE FEMALE

PRIMARY INSURANCE:			**SECONDARY INSURANCE:**		
INSURANCE NAME:			INSURANCE NAME:		
POLICY NUMBER:			POLICY NUMBER:		
PAYER PHONE:			PAYER PHONE:		
PROVIDER STATUS:	IN-NETWORK	OUT-OF-NETWORK	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 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: ____________________

PATIENT CONDITION BEING TREATED:

ICD-10 CODES:

TOTAL WOUND SIZE AND/OR DIMENSIONS (LIST ALL APPLICABLE WOUNDS):

ADDITIONAL INFO AND / OR MEDICAL HISTORY:

I CERTIFY THAT I HAVE RECEIVED THE NECESSARY PATIENT AUTHORIZATION TO RELEASE THE MEDICAL AND/OR PATIENT INFORMATION TO REIMBURSEMENT AND BILLING CORP (RMBB HEALTH) AND ITS AFFILIATES FOR THE PURPOSES OF OBTAINING ELIGIBILITY, BENEFITS, AUTHORIZATION, CLAIMS, APPEAL

PHYSICIAN SIGNATURE____________________ DATE ____________

DISCLAIMER: THIS SERVICE IS INTENDED FOR INFORMATIONAL PURPOSES ONLY AND DOES NOT REPRESENT A STATEMENT, PROMISE OR GUARANTEE OF REIMBURSEMENT, PAYMENT OR CHARGES. IT IS NOT INTENDED TO INCREASE OR MAXIMIZE REIMBURSEMENT. THE DECISION AS TO HOW TO COMPLETE A REIMBURSEMENT CLAIM FORM, INCLUDING AMOUNTS TO BILL, IS EXCLUSIVELY THE RESPONSIBILITY OF THE PROVIDER.