



PATIENT INSURANCE VERIFICATION REQUEST

Sales Rep:

Rep Email: info@biocoresolutions.us

New Request: Re-Verification: Additional Applications: New Insurance:

FACILITY AND PHYSICIAN INFORMATION

	Physician	Facility
Physician Name:	NPI:	
Physician Specialty:	Tax ID:	
Facility Name:	PTAN (Medicare #):	
Facility Address:	Medicaid #:	
City, State, Zip:	Phone #:	
Contact Name:	Fax #:	
Contact Email:		

Physician Office (POS 11)

Hospital Inpatient (POS 21)

Ambulatory Surgical Center (POS 24)

Hospital Outpatient (POS 22)

Nursing Facility (POS 32)

Assisted Living (POS 13)

Critical Access Hospital

Home (POS 12)

Other:

PATIENT INFORMATION

Patient Name:	Is the patient currently in a Skilled Nursing Facility? Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient Date of Birth:	Number of Days in SNF?
Patient Address:	Is the patient currently in a surgical global period? Yes <input type="checkbox"/> No <input type="checkbox"/>

INSURANCE INFORMATION

Primary	Secondary
Payer Name:	Payer Name:
Policy #:	Policy #:
Payer Phone #:	Payer Phone #:

Please fax in patient's face sheet and insurance cards. If Commercial/Medicare Advantage/Medicaid/Managed Medicaid, please fax in 4 weeks of chart notes.

PRODUCT

Q4205 Membrane Wrap	Q4290 Membrane Wrap Hydro	Q4344 Membrane Wrap Tri-Laye	Q4275 Esano ACA	Q4250 Amnio-AMP	Q4353 XCEED TL Matrix	Q4116 Cytal	A2005 Microlyte SAM
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Product Selected:

Wound Info

Wound Type	ICD-10 Codes	Previously Used Therapies:
Diabetic Foot Ulcer	Primary:	
Venous Leg Ulcer	Secondary:	
Chronic Ulcer	Wound Description	
Dehiscd Surgical Wound	Wound Location:	
Mohs Surgical Wound	Wound Duration:	Co - Morbities:
Other:	Post Debridement Total Size of Ulcers (cm ²):	

AUTHORIZED HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED

I certify that I have obtained a valid authorization under applicable law from the patient listed on this form (a) permitting me to release the patient's protected health information (PHI) to EMP and its contractors to research insurance coverage regarding products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to EMP and its contractors for the purposes of determining benefit coverage.

Authorized Signature:	Date:	
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