PATIENT INSURANCE VERIFICATION REQUEST

Fax: 1.855.537.5825 or 770.590.3575 Hotline Phone: 1.855.882.8903

All fields highlighted in **BOLD** are mandatory. Fields not bolded may be completed directly or included as an attachment (e.g., Patient Fact Sheet).

New Request: ☐ **Re-Verification:** ☐ **Additional Applications:** ☐ **New Insurance:** ☐ Sales Executive: _____

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 #:	
Primary Care Physician:		Salesforce Account #:	
Primary Care Physician Phone:			

Physician Office (POS 11) ☐ **Hospital Outpatient (POS 22)** ☐ **Ambulatory Surgical Center (POS 24)** ☐ **Home (POS 12)** ☐
Assisted Living (POS 13) ☐ **Nursing Facility (POS 32)** ☐ **Critical Access Hospital** ☐ **Hospital Inpatient (POS 21)** ☐ **Other** ☐

PATIENT INFORMATION

Patient Name:	Patient Date of Birth:
Patient Address:	Is the patient currently in a skilled nursing facility? Yes ☐ No ☐
Patient City, State, Zip:	Is the patient currently in a surgical global period? Yes ☐ No ☐

INSURANCE INFORMATION

PRIMARY		SECONDARY	
Is provider and facility in network?	Yes ☐ No ☐	Is provider and facility in network?	Yes ☐ No ☐
Payer Name:		Payer Name:	
Policy #:		Policy #:	
Payer Phone #:		Payer Phone #:	

Worker's Compensation Adjuster or VA Case Manager Name and Phone #: _____

Please fax system face sheet and insurance cards. If Commercial/Medicare Advantage/Medicaid/Managed Medicaid fax 4 weeks of clinical notes.

PRODUCT (CHECK)

☐ **EPIFIX or EPIFIX Mesh Allograft (Q4186)** ☐ **EPICORD or EPICORD Expandable Allograft (Q4187)** ☐ **EPIEFFECT Allograft (Q4278)** ☐ **AMNIOFIX Allograft (J3590)** ☐ **CELERA Allograft (Q4259)**

WOUND INFORMATION

WOUND TYPE (check)		ICD-10 CODES	TEST RESULTS	
Diabetic Foot Ulcer	☐	**Primary:**	HbA1C:	Date:
Venous Leg Ulcer	☐	**Secondary:**	ABI:	Date:
Chronic Ulcer	☐	WOUND DESCRIPTION	Serum creatinine:	Date:
Dehisced Surgical Wound	☐	**Location of Ulcer:**	Pre-Albumin/Albumin:	Date:
Mohs Surgical Wound	☐	**Duration of Ulcer:**	Procedural Date:	
Other:	☐	**Post Debridement Total Size of Ulcers (cm^2):**		

AUTHORIZED HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED

I certify that I have received the necessary patient authorization to release the medical and/or patient information to MIMEDX.

Authorized Signature: _____ **Date:** _____

Disclaimer: This document has been prepared for providers using MIMEDX and is intended for informational purposes only. This is a limited patient support program for MIMEDX patients only. It does not represent a statement, promise or guarantee by MIMEDX Group, Inc., concerning levels 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.