PATIENT INSURANCE VERIFICATION REQUEST FORM

PLEASE FAX FORM TO TRIAD LIFE SCIENCES REIMBURSEMENT HOTLINE: 888 980 1176

PHONE 888.767.4849 **EMAIL:** REIMBURSEMENT.WOUND@TRIADLS.COM

☐ NEW PATIENT ☐ RE-VERIFICATION ☐ ADDITIONAL APPLICATIONS ☐ NEW INSURANCE

TRIAD LIFE SCIENCES SALES REPRESENTATIVE NAME: ____________________

PATIENT AND INSURANCE INFORMATION

Patient Name:____________________ Date of Birth: ____________________

Address:____________________ City:____________________ State:____ Zip Code: ____________

Is the patient currently residing in a nursing home or skilled nursing facility? ☐ YES ☐ NO

If patient is currently under a surgical global period, please indicate date and procedure (CPT code) done:

Procedure (CPT) code(s):____________________ Date of Procedure: ____________

Primary Insurance:____________________ Policy #:____________________ Payer Phone #:____________

Secondary Insurance:____________________ Policy #:____________________ Payer Phone #: ____________

Tertiary Insurance:____________________ Policy #:____________________ Payer Phone #: ____________

Workers Comp Claim #:____________ Adjusters Name:____________________ Adjuster Phone #: ____________

PHYSICIAN AND FACILITY INFORMATION

Physicians Name and Specialty: ____________________

NPI #:____________________ Medicare (PTAN) Provider #:____________________

TAX ID:____________________ Medicaid Provider #: ____________________

Office Contact:____________________ Phone #:____________________ Fax #:____________________

TREATING FACILITY PLACE OF SERVICE (POS):

☐ Hospital-Based Outpatient Wound Department (HOPD – POS 22)

☐ Ambulatory Surgery Center (ASC – POS 24)

☐ Physician Office (POS – 11)

☐ Other (Please specify e.g., Critical Access Hospital or POS 19 Off Campus):

____

Facility Name: ____________________

Address:____________________ City:____________________ State:________ Zip Code: ____________

NPI #:____________________ Tax ID #: ____________________

Medicare contractor (MAC) and Provider ID (PTAN) for claims processing: ____________________

PRODUCT AND TREATMENT INFORMATION

Product: ☐ **InnovaMatrix® AC**		
Application Codes:		
Anticipated Treatment Start Date:	Number of Applications:	Frequency:

Total Surface Area of All Wounds:____________________

Diabetic Foot Ulcer	**Venous Leg Ulcer**	**Pressure Ulcer or Chronic Wound**	**Other**
E Code__________	I Code __________	L Code __________	__________
L Code__________	L Code __________		

AUTHORIZATION TO RELEASE INFORMATION

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form, permitting me to release the patient's protected health information to Triad Life Sciences Hotline and its contractors as necessary to obtain insurance coverage and payment information regarding Triad Life Sciences Products and Treatments.

Physician or Qualified Healthcare Professional Signature: ____________________ Date:____________

Please fax this form along with a copy of the front and back of the patient's insurance card(s) and any additional pertinent information such as the patient's demographic sheet to 888-980-1176.

Disclaimer: The Reimbursement Hotline is offered as an information service only. Please keep in mind that this information represents a summary of information provided by the insurer which may change from time to time. Third-party payment is affected by many factors; therefore, Triad Life Sciences cannot guarantee of coverage or reimbursement now or in the future. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any treatment rendered.