

# Patient Insurance Verification and Prior Authorization Request Form

New patient     Re-verification     Additional applications     New insurance

Sales representative name \_\_\_\_\_

## Patient and Insurance Information

Patient name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is the patient currently residing in a skilled nursing facility?  Yes  No    If yes, is the patient covered under a Part A stay?  Yes  No

**If patient is currently under a surgical global period, please indicate date and procedure completed**

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 # \_\_\_\_\_ Adjuster name \_\_\_\_\_ Adjuster phone \_\_\_\_\_

## Physician and Facility Information

Physician name \_\_\_\_\_ Physician 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 \_\_\_\_\_

Facility address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NPI # \_\_\_\_\_ Tax ID \_\_\_\_\_

Medicare contractor (MAC) and Provider ID (PTAN) for claims processing \_\_\_\_\_

## Product and Treatment Information

Product:  (Q4253) Zenith     (Q4262) Impax     (Q4268) SurGraft FT

Application codes: 15271 – 15274 for wounds on the trunks, arms, and/or legs

15275 – 15278 for wounds on the face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits

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 \_\_\_\_\_

*I certify 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 to Legacy Medical and its contractors to research insurance coverage regarding Legacy Medical products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to Legacy Medical and its contractors for the purposes of determining benefit coverage.*

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

**Please send form along with a copy of the front and back of patient's insurance card to [sunderwood@prodatamgmt.com](mailto:sunderwood@prodatamgmt.com) or fax to (866) 205-0732.**

If further assistance is needed, please contact IVR Support Team at (919) 249-7293 for additional support.

Disclaimer: Legacy Medical offers insurance verification as an information service only. Information gathered during the requested research will be provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement in the future. Legacy Medical disclaim liability for payment of any claims, benefits, or costs.