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 ❑ (Q4276) Orion ❑ (Q4173) PalinGen ❑ (A2001) InnovaMatrix

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 info@safehandsmaryland.com or fax to (410) 480-7081.

If further assistance is needed, please contact IVR Support Team at (443) 412-5656 for additional support.