TheraSkin Benefit Verification Request Form

Program Hours are 8:30am – 5:00 pm EST

TheraSkin Sales Rep: ___________________

Fax Completed Form to Toll-Free HIPAA-Compliant Fax: 855-325-4763
Questions? 877-222-2681

All fields required in order to best access patient eligibility and provider contract information.

Patient Demographic Information

Patient Name: ____ Social Security # ____

Address: ____ City, State, ZIP: ____

Phone #:____ Date of Birth: ______/_______/_______________________________________

Patient Wound Information

Select Wound Type: ☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐Pressure Ulcer ☐ Dehisced Surgical Wound ☐ Necrotizing Fasciitis ☐ Traumatic Burns ☐ Radiation Burns ☐ Other: __________________

Is Prior Authorization or Pre-Determination anticipated or required? ☐ **YES** ☐ **NO** **If yes: a copy of the patient's clinical records <u>must</u> be attached**

Product HCPCS: ☐ Q4121, Date of ***TheraSkin*** Application ______/_______/_________ Anticipated Number of Applications ______________

Application CPT(s): ☐ 15271 ☐ 15272 ☐ 15273 ☐ 15274 ☐ 15275 ☐ 15276 ☐ 15277 ☐ 15278

ICD-9 Diagnosis Code(s): Primary ICD-9 Diagnosis: ________________ Secondary ICD-9 Diagnosis: ________________ Other: _________________

Patient Insurance Information

Please include a front & back copy of patient's insurance card, if possible.

<u>Primary Insurance Information</u>
Participating Status (***select one***) ☐ In Network ☐ Out-of-Network

Insurance Name: ____

Policy #:____

Insurance Phone #:____

Subscriber Name: ____

Subscriber Date of Birth: _____/______/____________________________

<u>Secondary Insurance Information</u>
Participating Status (***select one***) ☐ In Network ☐ Out-of-Network

Insurance Name: ____

Policy #:____

Insurance Phone #:____

Subscriber Name: ____

Subscriber Date of Birth: _____/______/____________________________

Physician Information

TheraSkin Place of Service (POS): ☐ Office (POS 11) ☐ Inpatient Hosp (POS 21) ☐ Outpatient Hosp (POS 22) ☐ Ambulatory Surgical Center (POS 24)

Physician Name: __________________________________ Specialty: _______________ Site Name____

Address: ____ City, State, ZIP: ____

Contact Name: _____________________ Phone #:____________________ Fax # ______________________

NPI #_______________________________________ Tax ID #: _____________________________________

If Medicare, site bills to: ☐ Part A ☐ Part B
Contractor: _________________________
If blank, local Part B Jurisdiction assumed

Facility Information

TheraSkin Place of Service (POS): ☐ Office (POS 11) ☐ Inpatient Hosp (POS 21) ☐ Outpatient Hosp (POS 22) ☐ Ambulatory Surgical Center (POS 24)

Facility Name: ____

Address: ____ City, State, ZIP: ____

Contact Name: _____________________ Phone #:____________________ Fax # ______________________

NPI #_______________________________________ Tax ID #: _____________________________________

If Medicare, site bills to: ☐ Part A ☐ Part B
Contractor: _________________________
If blank, local Part Jurisdiction assumed

Physician Declaration

By signing below, I certify that I have received the necessary patient authorization to release the medical and/or other patient information referenced on the form relating to the above referenced patient. This information is for verifying insurance coverage, seeking reimbursement, and sole purpose of claim support.

____ ____________________________________

Physician or Authorized Signature **Date**