☐ Proactive ☐ Re-Verification ☐ Additional Applications ☐ OOPM ☐ New Insurance

Dermagraft® Benefit Verification Request Form

Phone: 866-866-7731 Fax: 866-866-7713 Program Hours: 9:00am – 8:00 pm EST

Patient Information (If face sheet is attached please ensure DOB, zip code, and insurance information is included)

Patient Name: ______________________ Social Security #: ______________ Male ☐ Female ☐

Address: ______________________ City, State, Zip: ______________________

Phone Number: ______________ Date of Birth: ______________

Is this patient currently residing in a Skilled Nursing Facility or Nursing Home? Yes ☐ No ☐

If yes, are they in a skilled bed? Yes ☐ No ☐ **If no**, are they in a long-term/custodial bed? Yes ☐ No ☐

Treatment Information

Date of 1st Application: ______________ Anticipated Number of Applications: ______________

Select One: ☐ Physician Office ☐ Hospital Outpatient ☐ Free Standing ASC ☐ Hospital-based ASC ☐ Critical Access Hospital ☐ Other: ______________

Diagnosis (please follow the 5 digit format within the ICD-9-CM coding system): Medicare claims require 1 ICD-9 code from each category.

Diabetic Codes	Ulcer Codes	Other Codes
☐ 250. ________ Diabetes Mellitus	☐ 707.14 Ulcer of the heel and midfoot	☐ ________ Other (Please Specify)
☐ 249. ________ Secondary Diabetes	☐ 707.15 Ulcer of other part of foot	☐ ________ Other (Please Specify)
☐ ________ Other (Please Specify)	☐ ________ Other (Please Specify)	
☐ No Diabetes		

☐ The Ulcer(s) or Wound(s) is/are >100 square centimeters

☐ If Prior Authorization is required or a Pre-Determination is recommended, please check here if you would like assistance from the Hotline

Patient Insurance Information

Primary Insurance Information (including Medicaid or Medicare)

Payer Name: ______________________

Policy #: ______________________

Group #: ______________________

Payer Phone#: ______________________

Subscriber Name/Relation: ______________________

Subscriber Date of Birth: ______________________

Secondary Insurance Information

Payer Name: ______________________

Policy #: ______________________

Group #: ______________________

Payer Phone#: ______________________

Subscriber Name/Relation: ______________________

Subscriber Date of Birth: ______________________

Physician and Facility Information

Physician Information

Participating Status (check one): ☐ In Network ☐ Out of Network

Physician Name: ______________________

Physician Specialty: ______________________

Practice Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone #: ______________________

Fax #: ______________________

Tax id#: ______________ NPI#: ______________

Payer Specific ID#: ______________________

Contact Name: ______________________

Facility Information

Participating Status (check one): ☐ In Network ☐ Out of Network

Facility Name: ______________________

Fiscal Intermediary: ______________________

Facility Address: ______________________

Facility City, State, Zip: ______________________

Phone #: ______________________

Fax #: ______________________

Tax ID#: ______________________

NPI#: ______________________

Payer Specific ID#: ______________________

Contact Name: ______________________

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 this form relating to the above referenced patient to Advanced BioHealing, Inc. and its agents or contractors for the purpose of using and re-disclosing this information, as necessary, for seeking reimbursement through the Dermagraft Reimbursement Hotline, verifying insurance coverage and claim support.

______________________________ ______________

***Physician Signature** **Date** **Dermagraft Representative Name**