



**WORLD REACH HEALTH**

# World Reach Health Patient Support Program Patient Insurance Verification Form

2 Ways to Submit IVR Request Form:

- Upload this form via your dedicated portal
- Email Form: reimbursement@healthtechwc.com

Account Representative Name: \_\_\_\_\_

Contact Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

DermaBind TL Q4225

DermaBind FM Q4313

## TYPE OF INSURANCE VERIFICATION REQUESTED

Please select one:  New Application  Prior Authorization  Additional Applications  Re-verification  Appeal/Denial Request (Please provide EOBs and denial documentation.)

## PATIENT INFORMATION: \*Please submit copies of insurance cards (front & back) and patient demographics sheet. Provide Medical Record Number (MRN) if available.

Patient Name:		DOB:	
Address:		MRN:	
City:	State:	Zip Code:	
Primary Ins:	Ins ID#	Group #:	Ins. Phone:
Secondary Ins:	Ins ID#	Group #:	Ins. Phone:
Is patient currently in a surgical global period? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what is the CPT surgery code?	Surgery Date?
Is patient currently residing in a nursing home or any in-patient facility? <input type="checkbox"/> Yes* <input type="checkbox"/> No		<i>*Reminder: Q Codes not separately payable while patient under part A episode of care.</i>	

## PROVIDER INFORMATION:

Place of Service:	<input type="checkbox"/> Physician Office (11)	<input type="checkbox"/> Home (POS 12)	<input type="checkbox"/> Nursing Facility (POS 32)	<input type="checkbox"/> Ambulatory Surgical Center (24)
	<input type="checkbox"/> HOPD (22)	<input type="checkbox"/> Other: Please List Place of Service (CAH, SNF): _____		
Rendering Physician Name:				
NPI:	TIN:		Medicare PTAN:	
Address:			Provider Phone:	
City/State:			Provider Fax:	
Primary Contact Person:			Contact Phone:	
Contact Email Address:			Contact Fax:	

## FACILITY INFORMATION:

Facility Name:	Facility Phone:	Facility Fax:
Facility Address:		
Facility NPI:	Facility TIN:	Medicare PTAN (Group):
Primary Contact Person:		Contact Phone:
Contact Email Address:		Contact Fax:

## PROCEDURE INFORMATION: \*Please attach all supporting clinical documentation such as treatment plan, progress notes, and LOMN.

Anticipated Treatment Start Date:	Wound Location:	Wound Size:
Diagnosis ICD-10 codes:		
<input type="checkbox"/> Diabetic Foot Ulcer <input type="checkbox"/> Venous Leg Ulcer <input type="checkbox"/> Lower Extremity Chronic Ulcer <input type="checkbox"/> Other: _____		
Number of Grafts:	Size of Initial Graft (in sq. cm):	
Additional Clinical Comments:		
Physician Signature:		Date:

*The signature above certifies that the physician has the necessary patient authorization to release the medical and/or patient information to COMPANY, its contractors and the patient's health insurance company as necessary to research insurance coverage and determine benefits related to COMPANY products. COVERAGE, REIMBURSEMENT AND/OR BENEFIT VERIFICATION FOR ANY PRODUCT OR PROCEDURE CANNOT BE GUARANTEED, AND THE COMPANY REIMBURSEMENT HOTLINE AND COMPANY DISCLAIM LIABILITY FOR PAYMENT OR NONPAYMENT OF ANY CLAIMS, BENEFITS OR COSTS. THIRD-PARTY PAYMENT FOR MEDICAL PRODUCTS AND SERVICES IS AFFECTED BY NUMEROUS FACTORS. IT IS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES AND MODIFIERS FOR SERVICES RENDERED.*