WORLD REACH HEALTH

World Reach Health Patient Support Program
Patient Insurance Verification Form

2 Ways to Submit IVR Request Form:

1) **Fax to 833-717-2940**

2) CLICK HERE FOR SECURE PORTAL
For reimbursement questions please call
1-833-381--2402

Account Representative Name: _____

Contact Email: _____

Phone Number: _____

Check only one box

☐ 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? ☐ Yes ☐ No	If yes, what is the CPT surgery code?		Surgery Date?
Is patient currently residing in a nursing home or any in-patient facility? ☐ Yes* ☐ No	*Reminder: Q Codes not separately payable while patient under part A episode of care.		

PROVIDER INFORMATION:

Place of Service: ☐ Physician Office (11) ☐ Home (POS 12) ☐ Nursing Facility (POS 32) ☐ Ambulatory Surgical Center (24)
☐ HOPD (22) ☐ 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:		

☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐ Lower Extremity Chronic Ulcer 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.
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Clear Form