

PATIENT INSURANCE VERIFICATION REQUEST FORM

PLEASE FAX FORM TO CONVATEC TRIAD LIFE SCIENCES REIMBURSEMENT HOTLINE: 888 980 1176

PHONE 888.767.4849

EMAIL: REIMBURSEMENT.WOUND@CONVATEC.COM

NEW PATIENT RE-VERIFICATION ADDITIONAL APPLICATIONS NEW INSURANCE

CONVATEC TRIAD LIFE SCIENCES SALES REPRESENTATIVE NAME: _____

PATIENT AND INSURANCE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Is the patient currently residing in a nursing home or skilled nursing facility? YES NO

If patient is currently under a surgical global period, please indicate date and procedure (CPT code) done:

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 #: _____ Adjusters Name: _____ Adjuster Phone #: _____

PHYSICIAN AND FACILITY INFORMATION

Physicians Name and 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) Physician Office (POS – 11)
 Ambulatory Surgery Center (ASC – POS 24) Other (Please specify e.g., Critical Access Hospital or POS 19 Off Campus): _____

Facility Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

NPI #: _____ Tax ID #: _____

Medicare contractor (MAC) and Provider ID (PTAN) for claims processing: _____

PRODUCT AND TREATMENT INFORMATION

Product: <input type="checkbox"/> InnovaMatrix® AC <input type="checkbox"/> InnovaMatrix® FS		
Application Codes:		
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 _____		

AUTHORIZATION TO RELEASE INFORMATION

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form, permitting me to release the patient's protected health information to Triad Life Sciences Hotline and its contractors as necessary to obtain insurance coverage and payment information regarding Triad Life Sciences Products and Treatments.

Physician or Qualified Healthcare Professional Signature: _____ Date: _____

Please fax this form along with a copy of the front and back of the patient's insurance card(s) and any additional pertinent information such as the patient's demographic sheet to 888-980-1176.

Disclaimer: The Reimbursement Hotline is offered as an information service only. Please keep in mind that this information represents a summary of information provided by the insurer which may change from time to time. Third-party payment is affected by many factors; therefore, Convatec Triad Life Sciences cannot guarantee of coverage or reimbursement now or in the future. It is the provider's responsibility to determine and submit the appropriate codes and modifiers for any treatment rendered.