Insurance Verification Request Form

Phone: (877) 805-5005
Fax: (855) 670-8057

smith&nephew OASIS® Wound Matrix

HOTLINE REIMBURSEMENT SERVICES

Research includes determining coverage and prior authorization requirements for OASIS Matrix and its application.

PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

Patient Name: Date of Birth: ☐ Female ☐ Male

Social Security Number: Address: City: State: Zip Code:

Primary Insurance: **Secondary Insurance:**

Payer Phone Number: Payer Phone Number:

Policy Number: Policy Number:

☐ If the patient has tertiary insurance, please check this box and fill out an additional Insurance Verification Request Form.

QUALIFIED HEALTHCARE PROFESSIONAL (QHP) AND FACILITY INFORMATION

Q.H.P. Name: Specialty:

Q.H.P. ID Numbers NPI Number: Tax ID Number: Medicaid Provider Number:

Office Contact: Phone Number: Fax Number:

Treatment Setting:
☐ Hospital-Based Outpatient Wound Department (HOPD) ☐ Physician Office
☐ Ambulatory Surgery Center (ASC) ☐ Skilled Nursing Facility (SNF)
☐ Inpatient Hospital, Acute ☐ LTCH

Facility Name:

Address: City: State: Zip Code:

Facility ID Numbers NPI Number: Tax ID Number:

Indicate Medicare MAC contractor that processes your claims:

OASIS MATRIX RESEARCH INFORMATION

Product: ☐ Q4102 OASIS Wound Matrix ☐ Q4124 OASIS Ultra Tri-Layer Matrix

PATIENT DIAGNOSIS CODES:

Primary: Secondary: Tertiary:

Other:

Note: ***Only diagnoses to be treated with OASIS Matrix should be provided. Please rank the diagnosis codes in the order in which they will be billed.***

Application Codes:

For Wounds on the Trunks, Arms, and/or Legs

☐ 15271/C5271 ☐ 15272/C5272 ☐ 15273/C5273 ☐ 15274/C5274

For Wounds on the Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, and/or Multiple Digits

☐ 15275/C5275 ☐ 15276/C5276 ☐ 15277/C5277 ☐ 15278/C5278

Note: *Check boxes from both rows for patients who have multiple wound locations.*

Anticipated treatment start date: Number of applications: Frequency:

AUTHORIZATION FOR RESEARCH The signatures of both the patient and provider are not required; only one is required.

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 the OASIS Navigator Hotline, to Smith & Nephew, Inc., and/or to its contractors (the "Smith & Nephew Parties") as necessary to obtain insurance coverage and payment information regarding OASIS Wound Matrix and/or OASIS Ultra Tri-Layer Matrix.

Signature of Qualified Healthcare Professional: _____ Date:_____

By signing this authorization, I, the patient, authorize my healthcare provider to use and/or disclose protected health information (PHI) related to OASIS Matrix products from my health records and insurance information to the "Smith & Nephew Parties" as necessary to obtain insurance coverage and payment information regarding OASIS Matrix products. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and will no longer be protected by federal privacy regulations. In carrying out these activities, the "Smith & Nephew Parties" may relay information to health insurer(s), receive information from health insurer(s), and communicate such information to my healthcare provider. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits. I understand that if I choose to revoke this authorization, I must do so in writing to my healthcare provider and that the revocation will apply to future disclosures only.

Patient Signature: _____ Date:_____

Please fax this form along with a copy of the front and back of the patient's insurance card to (855) 670-8057.

The OASIS Navigator Hotline is offered as an information service only. Please keep in mind that this information represents a summary of what the insurer told us. Third-party payment is affected by many factors; therefore, you should not interpret this letter as a guarantee of coverage or reimbursement now or in the future.