

**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 1<sup>st</sup> 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
<input type="checkbox"/> 250. _____ Diabetes Mellitus	<input type="checkbox"/> 707.14 Ulcer of the heel and midfoot	<input type="checkbox"/> _____ Other (Please Specify)
<input type="checkbox"/> 249. _____ Secondary Diabetes	<input type="checkbox"/> 707.15 Ulcer of other part of foot	<input type="checkbox"/> _____ Other (Please Specify)
<input type="checkbox"/> _____ Other (Please Specify)	<input type="checkbox"/> _____ Other (Please Specify)	
<input type="checkbox"/> 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