



INSURANCE VERIFICATION REQUEST

email: support@evotissue.com // office: 888-668-7698

PATIENT INFORMATION: LAST NAME: _____ FIRST NAME: _____ DOB: _____ PATIENT'S ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____	INSURANCE INFORMATION: PRIMARY INSURANCE: _____ PRIMARY POLICY #: _____ SECONDARY INSURANCE: _____ SECONDARY POLICY #: _____
REQUESTING PROVIDER INFORMATION: PROVIDER NAME: _____ PROVIDER NPI#: _____ TAX ID#: _____ PTAN#: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ OFFICE CONTACT NAME: _____ PHONE: _____ EXT: _____ FAX: _____	PLACE OF SERVICE INFORMATION: FACILITY NAME: _____ FACILITY NPI#: _____ TAX ID#: _____ ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ SERVICE TYPE: <input type="checkbox"/> OUTPT <input type="checkbox"/> OFFICE <input type="checkbox"/> SURGERY CTR <input type="checkbox"/> HOSPICE <input type="checkbox"/> OTHER _____

SERVICES

PRODUCT (CHECK ONE AND ADD UNITS):

DOS: _____

- ☐ Membrane Wrap (Q4205) _____ units/cm²
☐ Membrane Wrap – Hydro (Q4290) _____ units/cm²
☐ Tri-Membrane Wrap (Q4344) _____ units/cm²
☐ DermabindTL (Q4225) _____ units/cm²
☐ DermabindFM (Q4313) _____ units/cm²

- ☐ CompleteFT (Q4271) _____ units/cm²
☐ Restorign (Q4191) _____ units/cm²
☐ Colla-Derm (Q4193) _____ units/cm²
☐ careGraft (Q4322) _____ units/cm²
☐ alloPLY (Q4323) _____ units/cm²
☐ ACApatch (Q4325) _____ units/cm²

ICD-10 DIAGNOSIS CODE(S): _____

CPT APPLICATION CODE(S): _____



ALL SECTIONS OF THIS FORM MUST BE COMPLETED. ANY MISSING INFORMATION COULD DELAY THE PROCESSING TIME OF THE REQUEST. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM, PLEASE CONTACT THE CLIENT SERVICES TEAM.

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's evidence of coverage.

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