EvoGuard TISSUE SOLUTIONS

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:

☐ OUTPT ☐ OFFICE ☐ SURGERY CTR ☐ HOSPICE

☐ OTHER _____

SERVICES

PRODUCT (CHECK ONE AND ADD UNITS): DOS: _____

☐ Membrane Wrap (Q4205)	_____	units/cm^2	☐ CompleteFT (Q4271)	_____	units/cm^2
☐ Membrane Wrap – Hydro (Q4290)	_____	units/cm^2	☐ Restorigin (Q4191)	_____	units/cm^2
☐ Tri-Membrane Wrap (Q4344)	_____	units/cm^2	☐ Colla-Derm (Q4193)	_____	units/cm^2
☐ DermabindTL (Q4225)	_____	units/cm^2	☐ careGraft (Q4322)	_____	units/cm^2
☐ DermabindFM (Q4313)	_____	units/cm^2	☐ alloPLY (Q4323)	_____	units/cm^2
			☐ ACApatch (Q4325)	_____	units/cm^2

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.