

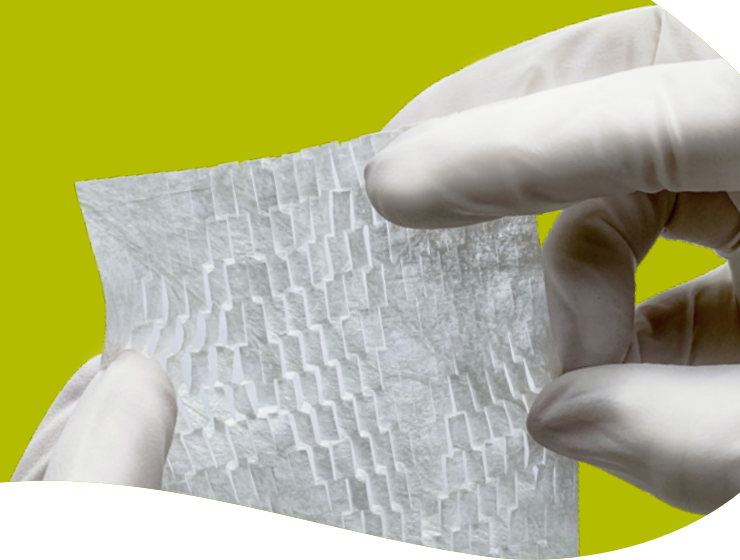
OASIS®
Wound Matrix

OASIS® ULTRA
Tri-Layer Matrix

OASIS®
Burn Matrix

Reimbursement guide 2025

Physician Office



Reimbursement Hotline Services

Phone: 866-988-3491

Fax: 866-304-6692

Additional fax: 443-472-4274

Customer Support

Phone: 888-674-9551

Reimbursement Hotline Services

For assistance with reimbursement questions, contact Smith+Nephew Reimbursement Hotline Services Monday through Friday from 8:00 am - 7:00 pm EST at **1-866-988-3491**.

Smith+Nephew Reimbursement Hotline Services staff can assist with the following:

- Patient-specific insurance verifications
- Payer policy and Medicare Local Coverage Determination (LCD) information
- Nurse Case Manager review of documentation and coding
- Prior authorization and pre-determination support

To initiate insurance verification support for your patients, please submit a complete **Insurance Verification Request (IVR) Form** with a signed practitioner authorization and fax to **866-304-6692**. The provider is responsible for verifying individual contract or reimbursement rates with each payer. Smith+Nephew Reimbursement Hotline Services is not able to confirm contracted or reimbursable rates on your behalf.

Reimbursement disclaimer

Information on reimbursement in the U.S. is provided as a courtesy. Due to the rapidly changing nature of the law and the Medicare payment policy, and reliance on information provided by outside sources, the information provided herein does not constitute a guarantee or warranty that reimbursement will be received or that the codes identified herein are or will remain applicable. This information is provided "AS IS" and without any other warranty or guarantee, expressed or implied, as to completeness or accuracy, or otherwise. This information has been compiled based on data gathered from many primary and secondary sources, including the American Medical Association, and certain Medicare contractors. Providers must confirm or clarify coding and coverage from their respective payers, as each payer may have differing formal or informal coding and coverage policies or decisions. Providers are responsible for accurate documentation of patient conditions and for reporting of products in accordance with particular payer requirements.

Medical necessity checklist

It is recommended that the provider review clinical evidence for OASIS® for indications of use, clinical outcomes, and frequency of applications. Providers should review applicable Medicare LCD or medical policy for OASIS and ensure all requirements and coverage guidelines are met.

Suggested documentation: The following should be documented in the patient's medical record based on current wound care standards:

- ☐ Duration of wound (# of days or weeks)
- ☐ Prior conservative treatments that have failed to induce significant wound healing
- ☐ Wound diagnosis (e.g. DFU, VLU, etc.); ICD 10 codes should report etiology and wound location
- ☐ Wound is free of infection and osteomyelitis (noted at each visit)
- ☐ Adequate treatment of the underlying disease(s) contributing to the non-healing wound
 - Documented diabetes management plan, appropriate offloading or compression if applicable
- ☐ Describe wound dressings applied and frequency of wound dressing changes
- ☐ Adequate blood flow / perfusion; documentation of tests used to assess perfusion
- ☐ Patient's nutritional status is adequate for healing
- ☐ For patients with history of Charcot neuroarthropathy, include documentation that acute Charcot Foot is not present, and any history of acute Charcot Foot has been treated
- ☐ If patient is a smoker, document patient was counselled that smoking inhibits wound healing, and resources for smoking cessation were provided
- ☐ Measurement of the wound progression at each visit (length x width x depth) Including at least twice in the last 30 days and before the first treatment (be specific about modalities such as debridement, advanced dressings, collagen, etc.)
- ☐ Wound appearance at each visit: amount of granulation tissue, amount and description of exudate and slough, appearance of wound edge
- ☐ Was appropriate wound preparation performed (e.g. debridement)? If not, explain why?
If yes, describe level of debridement and tissue removed at each visit
- ☐ Record skin substitute application number and improvement since last treatment at each visit
- ☐ Document skin substitute product size used, lot # and expiration date, amount discarded, if any.

| | | | | |
|---|--|-----------------------------------|---------------|---|
| 1. Type of Insurance Verification Requested: Prior Authorization support will be initiated if required by Payer, include clinical documentation to support PA | | | | |
| <input type="checkbox"/> New Wound <input type="checkbox"/> Subsequent Applications <input type="checkbox"/> Re-Verification <input type="checkbox"/> New Insurance <input type="checkbox"/> IVR Lite <input type="checkbox"/> I opt out of Prior Authorization support services | | | | |
| <input type="checkbox"/> Single Wound <input type="checkbox"/> Multiple Wounds | | Procedure Date: ____/____/____ | | |
| 2. Patient Information: Please list the patient's name on this form when attaching a face sheet | | | | |
| First Name: | | Last Name: | | M.I.: |
| Address: | | Apt./Suite#: | City: | State: Zip: |
| Date of Birth: | | Phone #: | | Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male |
| 3. Insurance Information: Please attach a copy (front & back) of patient's insurance card(s) | | | | |
| Cardholder Name: | | DOB: | | Relationship to patient: |
| Primary Payer: | | SSN: | | Plan Type: |
| Policy #: | | Group #: | | Card Phone #: |
| Secondary Payer: | | | | Plan Type: |
| Policy #: | | Group #: | | Card Phone #: |
| 4. Healthcare Provider (HCP) & Facility/Agency Information: Please note, we do not verify inpatient benefits. Provider must confirm Place of Service (POS). Select only ONE POS. | | | | |
| Place of Service: <input type="checkbox"/> Physician Office (POS11) <input type="checkbox"/> Hospital Outpatient Department (POS19/22) <input type="checkbox"/> Ambulatory Surgery Center (POS24) <input type="checkbox"/> Home Visit (POS12) <input type="checkbox"/> Assisted Living Facility (POS13) <input type="checkbox"/> Unskilled Nursing Bed (POS32) <input type="checkbox"/> Other POS: _____ | | | | |
| Skilled Nursing Facility: Provider is responsible for confirming skilled/unskilled status. Is the patient expected to be in a skilled bed on the date of service? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| HCP First Name: | | HCP Last Name: | | M.I.: |
| HCP NPI: | | HCP Tax ID#: | | |
| Specialty: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> PA <input type="checkbox"/> NP/FNP <input type="checkbox"/> Other: _____ | | | | |
| Contact Name: | | Phone #: | | |
| Facility Name: | | | Facility NPI: | |
| Facility Address: | | Facility Tax ID: | | |
| City, State, Zip: | | Phone #: | Fax #: | |
| 5. Treatment Information: If needed, select up to 3 products in order of preference numerically | | | | |
| ____ GRAFIX® PL PRIME Membrane (Q4133) ____ GRAFIX® PRIME Membrane (Q4133) ____ GRAFIX® CORE Membrane (Q4132) ____ GRAFIX® PLUS Membrane (Q4304) | | | | |
| ____ OASIS® Wound Matrix (Q4102) ____ OASIS® Burn Matrix (Q4103) ____ OASIS® ULTRA Tri-Layer Matrix (Q4124) | | | | |
| CPT: Legs/Arms/Trunk < 100 sq cm: ____ 15271/15272-C5271/C5272 Legs/Arms/Trunk > 100 sq cm: ____ 15273/15274-C5273/C5274 Feet/Hands/Head < 100 sq cm: ____ 15275/15276-C5275/C5276 Feet/Hands/Head > 100 sq cm: ____ 15277/15278-C5277/C5278 | | | | |
| NOTE: Prior use of skin substitutes or global periods related to the same wound may impact reimbursement | | | | |
| 6. Wound Information & Diagnosis Code(s): Please include ICD-10 codes that indicate Primary diagnosis, ulcer type, AND location. MUST include the full alpha-numeric ICD-10 Code. Ex: E11.621; L97.512; If treating more than one wound, please provide diagnosis codes for each additional wound | | | | |
| ICD-10 Codes: #1 Wound (Required) | | ICD-10 Codes: #2 Wound | | |
| Primary (Etiology): _____ | | Primary (Etiology): _____ | | |
| Secondary (Ulcer/Location): _____ | | Secondary (Ulcer/Location): _____ | | |
| Tertiary (Optional): _____ | | Tertiary (Optional): _____ | | |
| Wound Dimensions: L____W____D____ | | Wound Dimensions: L____W____D____ | | |
| 7. Prior Authorization: For PA support please attach all clinical notes related to the wound treatment episode | | | | |
| # of Anticipated Applications/Visits _____ Anticipated Units _____ | | | | |
| 8. Authorized Signature: Please include all required information and sign below | | | | |
| 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 (PHI) to the Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to GRAFIX PL®/GRAFIX® and/or OASIS® Matrix products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge. If prior authorization is required, I authorize Smith and Nephew to initiate the authorization. For typed or stamped signatures below: I agree that this typed or stamped signature has the same validity and meaning as my handwritten signature. | | | | |
| Authorized Signature: _____ | | | | Date: _____ |
| Disclaimer: The Smith+Nephew Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Smith & Nephew disclaims liability for payment of any claims, benefits or costs. | | | | |

CPT procedure codes and medicare payments

Medicare has designated specific CPT codes (15271-15278) for qualified healthcare providers to report the application of skin substitute graft procedures when applying CAMPs/skin substitute products. The selection of the code is based upon the location and size of the defect. Ensure the medical record reflects these elements and a procedure description including the fixation method.

Physicians applying Cellular, acellular and matrix-like products (CAMPs) in the office setting should report both the Current Procedural Terminology (CPT) application code(s) and the applicable OASIS® Matrix products' Healthcare Common Procedural Coding System (HCPCS) codes when submitting claims—Q4102 for OASIS® Wound Matrix, Q4103 for OASIS® Burn Matrix, Q4124 for OASIS® ULTRA Tri-Layer Matrix.

| Coding | | Physician office (Non-facility**) | Physician facility (HOPD) |
|-----------|--|--------------------------------------|--|
| CPT codes | Code description | Medicare National Average Payment | 2024 Medicare National Average Payment |
| 15271 | Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | \$148.47 | \$81.51 |
| +15272 | Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | \$23.61 | \$16.17 |
| 15273 | Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | \$295.00 | \$187.29 |
| +15274 | Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | \$76.98 | \$42.37 |
| 15275 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area | \$153.97 | \$90.57 |
| +15276 | Each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure) | \$31.70 | \$23.94 |
| 15277 | Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children | \$329.93 | \$215.75 |
| +15278 | Each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure) | \$91.22 | \$54.02 |

Important Notes: The Medicare payment amounts listed do not reflect adjustments for deductible, copayments, coinsurance, sequestration or any other reductions. All payment amounts listed are based on national averages and will vary by geographical locations. Commercial Payer Payment Rates It is commonly understood that the payment rates of a commercial payer for the application of skin substitutes (CPTs 15271-15278) and Cellular Tissue Product (CTP) used in the procedure (HCPCS code) are confidentially negotiated between the commercial payer and providers. During such negotiations, the commercial payer may use different methodologies to establish payment rates, such as Medicare Physician Fee Schedule (MPFS), payment based on a set percentage of charges, or bundled payment, where the CPT fee includes the Cellular Tissue Product. Providers participating in Value-Based Pricing agreements may also be paid on a per member per month basis. Additionally, those different rate-determining methodologies vary greatly among commercial payers. Therefore, to confirm payment rates, please consult your office practice manager or billing manager. If you are unable to identify your practice's contracted rates, please reach out to the specific payer's Provider Relations Representative. ** Commercial Payer Payment Rates It is commonly understood that the payment rates of a commercial payer for the application of skin substitutes (CPTs 15271-15278) and Cellular Tissue Product (CTP) used in the procedure (HCPCS code) are confidentially negotiated between the commercial payer and providers. During such negotiations, the commercial payer may use different methodologies to establish payment rates, such as Medicare Physician Fee Schedule (MPFS), payment based on a set percentage of charges, or bundled payment, where the CPT fee includes the Cellular Tissue Product. Providers participating in Value-Based Pricing agreements may also be paid on a per member per month basis. Additionally, those different rate determining methodologies vary greatly among commercial payers. Therefore, to confirm payment rates, please consult your office practice manager or billing manager. If you are unable to identify your practice's contracted rates, please reach out to the specific payer's Provider Relations Representative.

Reference: The Centers for Medicare and Medicaid Services, CY 2025 Physician Fee Schedule Final Rule, Addendum B, Retrieved from <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1807-f>

Product HCPCS Codes and Modifiers

OASIS® HCPCS Codes, UPC Codes and Billing Units:

All OASIS products are billed per square centimeter. One billable unit is 1 cm². To calculate the number of billable units multiply the length by the width of the wound cover that was applied. The below chart lists the assigned HCPCS codes for OASIS® Matrix and the billable units per product size.

In general, CAMPs/skin substitutes are reimbursed by Medicare based on the Average Sales Price (ASP) published quarterly by CMS on the cms.gov website under the ASP Drug Pricing File. The ASP rate is per square centimeter. In the absence of a published ASP by CMS, a product will be reimbursed based off Invoice or List Price (see Important Notes below). Please ask your OASIS Sales Representative or PARM for the currently effective ASP or List Price.

Providers must check contracted payment rates for private insurers.

| Product description | Part number | UPC code | Box quantity | Billing units (per sq cm) | HCPCS Q-code |
|---|------------------|----------------|--------------|---------------------------|--------------|
| OASIS® Wound Matrix 3 X 3.5 cm (11 cm ²) | 8213-1000-33 | 10827002466224 | 10 | 11 | Q4102 |
| OASIS Wound Matrix 3 X 7 cm (21 cm ²) | 8213-1000-37 | 10827002466262 | 10 | 21 | Q4102 |
| OASIS® Burn Matrix 3 X 3.5 cm (11 cm ²) | RQ: 8213-3000-16 | 10827002576046 | 5 | 11 | Q4103 |
| OASIS Burn Matrix 3 X 7 cm (21 cm ²) | RQ: 8213-3000-18 | 10827002576060 | 5 | 21 | Q4103 |
| OASIS Burn Matrix 5 X 7 cm (35 cm ²) | RQ: 8213-3000-13 | 10827002576039 | 5 | 35 | Q4103 |
| OASIS Burn Matrix 7 X 10 cm (70 cm ²) | RQ: 8213-3000-09 | 10827002576015 | 5 | 70 | Q4103 |
| OASIS Burn Matrix 7 X 20 cm (140 cm ²) | RQ: 8213-3000-11 | 10827002576022 | 5 | 140 | Q4103 |
| OASIS® ULTRA Tri-Layer Matrix 3 X 3.5 cm (11 cm ²) | 8213-0000-16 | 10827002352428 | 5 | 11 | Q4124 |
| OASIS ULTRA Tri-Layer Matrix 3 X 7 cm (21 cm ²) | 8213-0000-18 | 10827002352442 | 5 | 21 | Q4124 |
| OASIS ULTRA Tri-Layer Matrix 5 X 7 cm (35 cm ²) | 8213-0000-13 | 10827002231198 | 5 | 35 | Q4124 |
| OASIS ULTRA Tri-Layer Matrix 7 X 10 cm (70 cm ²) | 8213-0000-09 | 10827002564630 | 5 | 70 | Q4124 |
| OASIS ULTRA Tri-Layer Matrix 7 X 20 cm (140 cm ²) | 8213-0000-11 | 10827002564654 | 5 | 140 | Q4124 |

Important notes:

1. CMS instructions indicate that payment for drugs and biologicals that are not included in the ASP File are based on the published wholesale acquisition cost (WAC) or invoice price. The payment limit is typically 103 to 106 percent of the lesser of the lowest priced brand or median generic WAC. Physician offices should verify if the Medicare Administrative Contractor (MAC) that processes their claims, covers the product and whether the MAC pays for it based on WAC or invoice price.
 - a. If the MAC pays for the product based on WAC, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
 - Product name
 - NDC code
 - WAC of product
 - WAC per sq. cm.
 - Source of the WAC (e.g., Red Book)
 - b. If the MAC pays for the product based on invoice price, the following information should be included in field 19 of a paper claim or in the narrative field of an electronic claim:
 - Product name
 - Product size (in sq. cm.)
 - Product number
 - Invoice price per piece
 - Shipping cost
2. The Medically Unlikely Edit (MUE) is the maximum units of a product reimbursed in one application per day. The MUE for Oasis® products are as follows: a. OASIS® Wound Matrix (Q4102) = 21 units. b. MUE for Oasis® Burn Matrix (Q4103) is not set. c. OASIS® ULTRA Tri-Layer Matrix (Q4124) = 140 units. Note: MUE data as of 2019.
3. Payers including some MACs will require use of certain modifiers. Please check with the patient's insurance plan or MAC to identify whether modifiers are required with Q4102, Q4103 or Q4124.
 - a. Common Modifiers:
 - i. JC – skin substitute used as a graft
 - ii. KX-provider deems continued care reasonable and necessary
 - iii. JW – discarded skin substitute, not used (wastage)
 - iv. JZ - zero discarded skin substitute, no wastage

ICD-10 diagnosis code guidelines for wound care

OASIS® Wound Matrix, OASIS® Burn Matrix and OASIS® ULTRA Tri-Layer coverage is based on medical necessity and subject to payer coverage guidelines. Always refer to the product Instructions for Use (IFU) or package insert for guidance on appropriate use.

OASIS Wound Matrix, OASIS Burn Matrix and OASIS ULTRA Tri-Layer Matrix are indicated for the following types of wounds:

- Partial and full-thickness wounds
- Pressure ulcers
- Venous ulcers
- Chronic vascular ulcers
- Tunneled, undermined wounds
- Diabetic ulcers
- Trauma wounds (abrasions, lacerations, second-degree burns, skin tears)
- Draining wounds
- Surgical wounds (donor sites/grafts, post-Mohs surgery, podiatric, wound dehiscence)

It is recommended that providers select the most specific primary and secondary diagnosis codes to accurately describe the reason the wound is not healing properly, and codes that indicate the wound is chronic and describe the location, severity, and laterality.

Example of specific DFU codes:

- Primary diagnosis:
E11.621, type 2 diabetes mellitus with a foot ulcer
- Secondary diagnosis:
L97.522, non-pressure chronic ulcer of other part of left foot with fat layer exposed

Example of specific VLU codes:

- Primary diagnosis:
I87.312, chronic venous hypertension (idiopathic) with ulcer of left lower extremity
- Secondary diagnosis:
L97.222, non-pressure chronic ulcer of left calf with fat layer exposed

These codes are provided for information only and are not a statement or guarantee of reimbursement. The provider is ultimately responsible for verifying coverage with the patient's payer source.

The ICD-10 codes listed below represent some of the etiology diagnosis codes commonly associated with causes of lower extremity chronic ulcers. This is not meant to be an exhaustive list. Codes were selected from internal benefit investigation data and represent the most common codes submitted to the S+N Reimbursement Hotline.

Common ICD-10 codes associated with chronic lower extremity ulcers

| Code | Description |
|---------|---|
| | Diabetic ulcer codes (not meant to be an exhaustive list) |
| E10.621 | Type 1 diabetes mellitus with foot ulcer |
| E10.622 | Type 1 diabetes mellitus with other skin ulcer |
| E11.621 | Type 2 diabetes mellitus with foot ulcer |
| E11.622 | Type 2 diabetes mellitus with other skin ulcer |
| E13.621 | Other specified diabetes mellitus with foot ulcer |
| | Venous Ulcer Codes (not meant to be an exhaustive list) |
| I83.012 | Varicose veins of right lower extremity with ulcer of calf |
| I83.013 | Varicose veins of right lower extremity with ulcer of ankle |
| I83.014 | Varicose veins of right lower extremity with ulcer of heel & midfoot |
| I83.015 | Varicose veins of right lower extremity with ulcer of other part of foot |
| I83.018 | Varicose veins of right lower extremity with ulcer of other part of lower leg |
| | Non-Pressure Chronic Ulcer of Lower Limb |
| L97.211 | Non-Pressure Chronic Ulcer of right calf limited to breakdown of skin |
| L97.212 | Non-Pressure Chronic Ulcer of right calf with fat layer exposed |
| L97.221 | Non-Pressure Chronic Ulcer of left calf limited to breakdown of skin |
| L97.222 | Non-Pressure Chronic Ulcer of left calf with fat layer exposed |
| L97.311 | Non-Pressure Chronic Ulcer of right ankle limited to breakdown of skin |

Please see the product's Instructions for Use (IFU) for indications, contraindications, warnings, precautions and other important information.

Advanced Wound Management
Smith+Nephew, Inc.
Fort Worth, TX 76109 USA

⁹GRAFIX, GRAFIX CORE, GRAFIX PLUS and GRAFIX PRIME are trademarks of Osiris Therapeutics, Inc., a wholly owned direct subsidiary of Smith & Nephew Consolidated, Inc.

Oasis® is manufactured by:
Cook Biotech, Inc.
1425 Innovation Place
West Lafayette, IN 47906

Oasis® is distributed by:
Advanced Wound Management
Smith & Nephew Inc.
Fort Worth, TX 76109

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MSFE6-41607-1024





Sample Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| PICA | | | | | | | | | | PICA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA/DK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> | | | | | | | | | | 1a. INSURED'S I.D. NUMBER (For Program in Item 1) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. PATIENT'S ADDRESS (No., Street) | | | | | | | | | | 6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | | | | 7. INSURED'S ADDRESS (No., Street) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CITY | | | | | | | | | | STATE | | | | | | | | | | CITY | | | | | | | | | | STATE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ZIP CODE | | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | ZIP CODE | | | | | | | | | | TELEPHONE (Include Area Code) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | | | | | | | | | 10. IS PATIENT'S CONDITION RELATED TO: | | | | | | | | | | 11. INSURED'S POLICY GROUP OR FECA NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | | | | | | | | | a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. RESERVED FOR NUCC USE | | | | | | | | | | b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) | | | | | | | | | | b. OTHER CLAIM ID (Designated by NUCC) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. RESERVED FOR NUCC USE | | | | | | | | | | c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | | | | | | | | | | 10d. CLAIM CODES (Designated by NUCC) | | | | | | | | | | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. | | | | | | | | | | | | | | | | | | | | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SIGNED _____ | | | | | | | | | | | | | | | | | | | | SIGNED _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. SERVICE DESCRIPTION | | | | | | | | | | | | | | | | | | | | 15. OTHER DATE QUAL MM DD YY | | | | | | | | | | | | | | | | | | | | 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | |
| 17. DATE OF SERVICE | | | | | | | | | | | | | | | | | | | | 17a. NPI | | | | | | | | | | | | | | | | | | | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY | | | | | | | | | | | | | | | | | | | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) | | | | | | | | | | | | | | | | | | | | 20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES | | | | | | | | | | | | | | | | | | | | 22. RESUBMISSION ORIGINAL REF. NO. | | | | | | | | | | | | | | | | | | | |
| OASIS WOUND MATRIX (3 x 3.5) per sq cm | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Re | | | | | | | | | | | | | | | | | | | | Primary and Secondary ICD-10 Codes | | | | | | | | | | | | | | | | | | | | Product & Procedure Charges | | | | | | | | | | | | | | | | | | | |
| A. 187.312 | | | | | | | | | | | | | | | | | | | | B. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C. 187.312 | | | | | | | | | | | | | | | | | | | | D. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E. 187.312 | | | | | | | | | | | | | | | | | | | | F. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| G. 187.312 | | | | | | | | | | | | | | | | | | | | H. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I. 187.312 | | | | | | | | | | | | | | | | | | | | J. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| K. 187.312 | | | | | | | | | | | | | | | | | | | | L. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| M. 187.312 | | | | | | | | | | | | | | | | | | | | N. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| O. 187.312 | | | | | | | | | | | | | | | | | | | | P. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Q. 187.312 | | | | | | | | | | | | | | | | | | | | R. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| S. 187.312 | | | | | | | | | | | | | | | | | | | | T. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| U. 187.312 | | | | | | | | | | | | | | | | | | | | V. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| W. 187.312 | | | | | | | | | | | | | | | | | | | | X. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y. 187.312 | | | | | | | | | | | | | | | | | | | | Z. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AA. 187.312 | | | | | | | | | | | | | | | | | | | | AB. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AC. 187.312 | | | | | | | | | | | | | | | | | | | | AD. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AE. 187.312 | | | | | | | | | | | | | | | | | | | | AF. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AG. 187.312 | | | | | | | | | | | | | | | | | | | | AH. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AI. 187.312 | | | | | | | | | | | | | | | | | | | | AJ. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AK. 187.312 | | | | | | | | | | | | | | | | | | | | AL. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AM. 187.312 | | | | | | | | | | | | | | | | | | | | AN. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| CT. 187.312 | | | | | | | | | | | | | | | | | | | | CU. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CU. 187.312 | | | | | | | | | | | | | | | | | | | | CV. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CV. 187.312 | | | | | | | | | | | | | | | | | | | | CW. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CW. 187.312 | | | | | | | | | | | | | | | | | | | | CX. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CX. 187.312 | | | | | | | | | | | | | | | | | | | | CY. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DB. 187.312 | | | | | | | | | | | | | | | | | | | | DC. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DC. 187.312 | | | | | | | | | | | | | | | | | | | | DD. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DD. 187.312 | | | | | | | | | | | | | | | | | | | | DE. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DF. 187.312 | | | | | | | | | | | | | | | | | | | | DG. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DG. 187.312 | | | | | | | | | | | | | | | | | | | | DH. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DJ. 187.312 | | | | | | | | | | | | | | | | | | | | DK. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DL. 187.312 | | | | | | | | | | | | | | | | | | | | DM. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DM. 187.312 | | | | | | | | | | | | | | | | | | | | DN. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| DQ. 187.312 | | | | | | | | | | | | | | | | | | | | DR. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DR. 187.312 | | | | | | | | | | | | | | | | | | | | DS. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DS. 187.312 | | | | | | | | | | | | | | | | | | | | DT. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| IL. 187.312 | | | | | | | | | | | | | | | | | | | | IM. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IM. 187.312 | | | | | | | | | | | | | | | | | | | | IN. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN. 187.312 | | | | | | | | | | | | | | | | | | | | IO. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IO. 187.312 | | | | | | | | | | | | | | | | | | | | IP. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IP. 187.312 | | | | | | | | | | | | | | | | | | | | IQ. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IQ. 187.312 | | | | | | | | | | | | | | | | | | | | IR. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IR. 187.312 | | | | | | | | | | | | | | | | | | | | IS. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IS. 187.312 | | | | | | | | | | | | | | | | | | | | IT. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IT. 187.312 | | | | | | | | | | | | | | | | | | | | IU. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IU. 187.312 | | | | | | | | | | | | | | | | | | | | IV. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IV. 187.312 | | | | | | | | | | | | | | | | | | | | IW. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IW. 187.312 | | | | | | | | | | | | | | | | | | | | IX. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IX. 187.312 | | | | | | | | | | | | | | | | | | | | IY. L97.222 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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