Smith+Nephew

Smith+Nephew Reimbursement Hotline Services
GRAFIX® Membrane and OASIS® Matrix
Insurance Verification Request (IVR) Form
Phone: 866-988-3491 Fax: 866-304-6692

1. Type of Insurance Verification Requested: Prior Authorization support will be initiated if required by Payer, include clinical documentation to support PA

☐ **New Wound** ☐ **Subsequent Applications** ☐ **Re-Verification** ☐ **New Insurance** ☐ **IVR Lite** ☐ **I opt out of Prior Authorization support services**

☐ **Single Wound** ☐ **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: ☐ Female ☐ 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: ☐ Physician Office (POS11) ☐ Hospital Outpatient Department (POS19/22) ☐ Ambulatory Surgery Center (POS24) ☐ Home Visit (POS12) ☐ Assisted Living Facility (POS13) ☐ Unskilled Nursing Bed (POS32) ☐ 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? ☐ Yes ☐ No

HCP First Name:	HCP Last Name:	M.I.:
HCP NPI:	HCP Tax ID#:	

Specialty: ☐ MD ☐ DO ☐ DPM ☐ PA ☐ NP/FNP ☐ 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)
Primary (Etiology): _____
Secondary (Ulcer/Location): _____
Tertiary (Optional): _____
Wound Dimensions: L_____W_____D_____

ICD-10 Codes: #2 Wound
Primary (Etiology): _____
Secondary (Ulcer/Location): _____
Tertiary (Optional): _____
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.

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