Insurance Verification Request Form

Phone: (888) 705-0061
Fax: (800) 472-3848

smith&nephew OASIS® Wound Matrix

HOTLINE REIMBURSEMENT SERVICES

Research includes determining coverage and prior authorization requirements for OASIS Matrix and its application.

PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

Patient Name: Date of Birth: ☐ Female ☐ Male

Social Security Number: Address: City: State: Zip Code:

Primary Insurance: **Secondary Insurance (no Supplemental):**

Payer Phone Number: Payer Phone Number:

Policy Number: Policy Number:

☐ If the patient has tertiary insurance, please check this box and fill out an additional Insurance Verification Request Form.

QUALIFIED HEALTHCARE PROFESSIONAL (QHP) AND FACILITY INFORMATION

Q.H.P. Name: Specialty:

Q.H.P. NPI or Tax ID Number: Is QHP In Network with Payer? ☐ Yes ☐ No ☐ Unknown

Medicaid Provider Number:

Office Contact: Phone Number: Fax Number:

Treatment Setting:
☐ Hospital-Based Outpatient Wound Department (HOPD)
☐ Ambulatory Surgery Center (ASC)
☐ Inpatient Hospital, Acute
☐ Physician Office
☐ Skilled Nursing Facility (SNF)
☐ LTCH

Facility Name:

Address: City: State: Zip Code:

Facility NPI or Tax ID Number: Is Facility In Network with Payer? ☐ Yes ☐ No ☐ Unknown

Indicate Medicare MAC contractor that processes your claims:

OASIS MATRIX RESEARCH INFORMATION (ICD-10-CM Diagnosis codes require a greater level of specificity including an exact anatomical location, etiologies, comorbidities and complications to demonstrate severity of illness.)

Product: ☐ Q4102 OASIS Wound Matrix ☐ Q4124 OASIS Ultra Tri-Layer Matrix ☐ Q4103 OASIS Burn Matrix

PATIENT ICD-10-CM DIAGNOSIS CODES Only (see note above)

Primary: Secondary: Tertiary:

Other:

Note: Only diagnoses to be treated with OASIS Matrix should be provided. Please rank the diagnosis codes in the order in which they will be billed.

Application Codes:

For Wounds on the Trunks, Arms, and/or Legs

☐ 15271/C5271 ☐ 15272/C5272 ☐ 15273/C5273 ☐ 15274/C5274

For Wounds on the Face, Scalp, Eyelids, Mouth, Neck, Ears, Orbits, Genitalia, Hands, Feet, and/or Multiple Digits

☐ 15275/C5275 ☐ 15276/C5276 ☐ 15277/C5277 ☐ 15278/C5278

Note: Check boxes from both rows for patients who have multiple wound locations.

Anticipated treatment start date: Number of applications: Frequency:

AUTHORIZATION FOR RESEARCH The signatures of both the patient and provider are not required; only one is required.

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 to the OASIS Navigator Hotline, to Smith & Nephew, Inc., and/or to its contractors (the "Smith & Nephew Parties") as necessary to obtain insurance coverage and payment information regarding OASIS Wound Matrix, OASIS Ultra Tri-Layer Matrix, and/or OASIS Burn Matrix.

Signature of Qualified Healthcare Professional: _____ Date: _____

By signing this authorization, I, the patient, authorize my healthcare provider to use and/or disclose protected health information (PHI) related to OASIS Matrix products from my health records and insurance information to the "Smith & Nephew Parties" as necessary to obtain insurance coverage and payment information regarding OASIS Matrix products. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and will no longer be protected by federal privacy regulations. In carrying out these activities, the "Smith & Nephew Parties" may relay information to health insurer(s), receive information from health insurer(s), and communicate such information to my healthcare provider. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits. I understand that if I choose to revoke this authorization, I must do so in writing to my healthcare provider and that the revocation will apply to future disclosures only.

Patient Signature: _____ Date: _____

Please fax this form along with a copy of the front and back of the patient's insurance card to (800) 472-3848.

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Questions? Please call the Smith and Nephew Reimbursement Hotline at: 1-888-705-0061

Information on reimbursement in the US is provided as a courtesy. Due to the rapidly changing nature of the law and Medicare payment policy, and our reliance on information provided by outside sources, the information provided herein does not constitute a guarantee or warranty by Smith & Nephew 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. Physicians and other providers must confirm or clarify coverage and coding from their respective payers, as each payer may have differing formal or informal coding and coverage policies or decisions. Physicians and providers are responsible for accurate documentation of patient conditions and for reporting procedures and products in accordance with particular payer requirements.

smith&nephew
Supporting healthcare professionals for over 150 years

For detailed product information, including indications for use, contraindications, precautions and warnings, please consult the product's Instructions for Use (IFU) prior to use.

Manufactured by:
Cook Biotech, Inc.
1425 Innovation Place
West Lafayette, IN 47906

Distributed by:
Advanced Wound Management
Smith & Nephew, Inc.
Fort Worth, TX 76109
USA

OMME1-14119-0319