Patient Insurance Verification and Prior Authorization Request Form

o New patient o Re-verification o Additional applications o New insurance

Sales representative name _____

Patient and Insurance Information

Patient name	Date of birth		
Address	City	State	Zip

Is the patient currently residing in a skilled nursing facility? o Yes o No If yes, is the patient covered under a Part A stay? o Yes o No

If patient is currently under a surgical global period, please indicate date and procedure completed

Procedure (CPT) code(s)		Date of procedure
Primary insurance	Policy #	Payer phone
Secondary insurance	Policy #	Payer phone
Tertiary insurance	Policy #	Payer phone
Workers comp claim #	Adjuster name	Adjuster phone

Physician and Facility Information

Physician name	Physician specialty	
NPI #	Medicare (PTAN) provider #	
Tax ID	Medicaid provider #	
Office contact	Phone	Fax

Treating facility place of service (POS)
o Hospital-based outpatient wound department (HOPD – POS 22) o Ambulatory surgery center (ASC – POS 24)
o Physician office (POS 11)
o Other (please specify, e.g. critical access hospital or POS 19 off-campus) _____

Facility name			
Facility address	City	State	Zip
NPI #	Tax ID		
Medicare contractor (MAC) and Provider ID (PTAN) for claims processing			

Product and Treatment Information

Product: ❑ MEMBRANE WRAP ❑ MEMBRANE WRAP-HYDRO ❑ TRI-MEMBRANE WRAP

Application codes: 15271 – 15274 for wounds on the trunks , arms, and/or legs
15275 – 15278 for wounds on the face , scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits

Anticipated treatment start date	Number of applications	Frequency
Total surface area of all wounds		

Diabetic foot ulcer	**Venous leg ulcer**	**Pressure ulcer or chronic wound**	**Other**
E code	I code	L code	
L code	L code		

*I certify I have obtained a valid authorization under applicable law from the patient listed on this form (a) permitting me to release the patient's protected health information to A & O Medical Medical and its contractors to research insurance coverage regarding A & O Medical products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to **A & O** Medical and its contractors for the purposes of determining benefit coverage.*

Provider signature _____ Date _____

Please send form along with a copy of the front and back of patient's insurance card to infoanomedical@gmail.com or fax to +1 424-502-1762.

If further assistance is needed, please contact IVR Support Team at +1 424-502-1762 for additional support.