tidesmedical Intake Form

Hotline Contact Info
Phone: 1-800-318-9419
E-fax: 337-205-3599

Rep Name: ______________________ Email: ______________________

PHYSICIAN INFORMATION

Physician Name	NPI	Tax ID
Practice Name	Phone	Fax
Address, City, State Zip		
Office Contact Name	Physician Specialty	
Office Contact Email	Preferred Method of Contact to Receive Response Form ☐ Fax ☐ Email	

FACILITY INFORMATION

Facility Name	NPI	Tax ID
Phone	Fax	
Address, City, State Zip		

PATIENT INFORMATION

Patient Name	Phone	Date of Birth
Address, City, State Zip		

INSURANCE INFORMATION

Primary Insurance	Member ID	Phone
Secondary Insurance	Member ID	Phone

PROCEDURE

Skin Graft Substitute
☐ Q4169 (Artacent® Wound)

Procedure Date

Diagnosis Codes

Requested Number of Applications

Place of Service
☐ Inpatient ☐ Outpatient (HOPD) ☐ ASC ☐ Office ☐ Other

Graft Application
- ☐ 15271: Application of graft to trunk, arms, legs, total wound surface area up to 100cm^2; First 25cm^2 wound surface area or less
- ☐ 15273: Application of graft to trunk, arms, legs, total wound surface area greater than or equal to 100cm^2; First 100cm^2 wound surface area
- ☐ 15275: Application of graft to face, scalp, feet, etc. total wound surface area up to 100cm^2; First 25cm^2 wound surface area or less
- ☐ 15277: Application of graft to face, scalp, feet, etc. total wound surface area greater than or equal to 100cm^2; First 100cm^2 wound surface area

HIPAA AUTHORIZATION

By signing below I certify that I have received the necessary patient consent to release the medical and/or other patient information referenced on this form to Tides Medical® for the purpose of using and re-disclosing this information, as necessary, for insurance verification, prior authorization, and/or claims support. I understand this consent must be specific to Tides Medical.

If you need a release form, please contact the Reimbursement Hotline at 1-800-318-9419.

Physician Signature	Date

The Tides Medical® Hotline is an information service program. Reimbursement and coverage results are based on the information provided to Tides Medical® from the third party payer. Coverage are reimbursement are subject to change at any time. The Hotline results are not a guarantee of coverage and payment now or in the future.

Fax this form to Reimbursement Services: 337-205-3599

Authorization to Share Health Information

By signing this Authorization, I give my permission for my health care provider/physician, health insurance company, and pharmacy providers (“Healthcare Providers”) to share with Tides Medical, its affiliates, and vendors and other companies working with Tides Medical (collectively, “Tides”), health information relating to my medical condition, treatment, and insurance coverage so that Tides may (i) enroll me in and provide me with support services (and related information and materials) related to Tides products, including but not limited to, helping to verify and coordinate reimbursement for Tides products, including financial assistance if I am eligible, and providing me with online support, and other therapy support services, (ii) communicate with my Healthcare Providers about my support services, (iii) conduct quality assurance, and other internal business activities, and (iv) provide me with information about Tides products, services, and other disease management and education programs and materials, including sending me surveys about my experience with Tides products, services, and programs. Once my health information has been disclosed to Tides, I understand that federal privacy laws no longer protect the information. However, Tides agrees to protect my health information by using and disclosing it only for purposes authorized in this Authorization or as required by law or regulations. I understand that my pharmacy provider may receive remuneration from Tides in exchange for the health information and/or for any therapy support services provided to me.

I understand that I may refuse to sign this Authorization. I further understand that my treatment and insurance enrollment or eligibility for insurance benefits are not conditioned upon my agreement to sign this Authorization; but if I do not sign it or later cancel it, I will not be able to receive Tides’ support services. I may cancel this Authorization at any time by mailing a letter to: Tides, 1819 Pinhook Road, Suite 109, Lafayette, LA 70508. Canceling this Authorization will end my consent to further disclosure of my health information to Tides by my Healthcare Providers after they are notified of my cancellation, but will not affect previous disclosures by them pursuant to this Authorization. Canceling this Authorization will not affect my ability to receive treatment, payment for treatment, or my eligibility for health insurance. This Authorization expires ten (10) years, or such shorter timeframe required by applicable law, from the day I sign it as indicated by the date next to my signature unless otherwise canceled earlier as set forth above. I understand I have a right to receive a copy of this form.

I give permission for Tides to contact me by mail, email, fax, telephone call, and text, including through an automatic telephone dialing system or prerecorded voice, at the number(s) and address(es) provided on the enrollment form for all non-marketing purposes described in this Authorization. I may also consent below to receive marketing calls and texts. I confirm I am the subscriber for the telephone number(s) provided and the authorized user for the e-mail address(es) provided and agree to notify Tides promptly if any of my contact information changes. I understand that my wireless service provider’s message and data rates may apply.

____________________________________ __________________________

Signature of Patient or Patient’s Representative Date

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Printed Name

If signed by patient representative, please explain your authority to act on behalf of the patient.