

tidesmedical[®] Benefits Verification Form

Agent Name: _____ Agent Email: _____

Type of Insurance Requested			
<input type="checkbox"/> New patient <input type="checkbox"/> Re-verification <input type="checkbox"/> New insurance <input type="checkbox"/> Additional applications			
Patient & Insurance Information *Name & DOB required. List patient's name on this form when attaching a face sheet.			
Patient Name*		Date of Birth*	
Address	City	State	ZIP
Is the patient currently residing in a skilled nursing facility and receiving Part A benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the patient currently in a surgical global period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Insurance	Member ID	Phone	
Secondary Insurance	Member ID	Phone	
Provider & Facility Information			
Provider Name*		Provider Tax ID	
Provider NPI		PTAN#	
Facility Name			
Address	City	State	ZIP
Facility NPI	Facility Tax ID	Facility PTAN#	
Phone	Fax	Preferred Contact Method <input type="checkbox"/> Fax <input type="checkbox"/> Email	
Facility Contact Name	Phone	<input type="checkbox"/> Portal	
Email Address	Fax		
Product & Treatment Information			
Product*	<input type="checkbox"/> APLICOR 3D [®] <input type="checkbox"/> Artacent AC [®] <input type="checkbox"/> Artacent Vericlen [®] <input type="checkbox"/> Artacent Wound [®] <input type="checkbox"/> Biovance [®] <input type="checkbox"/> MLG Complete [™] <input type="checkbox"/> Other: _____		Anticipated Application Date:
	Diagnosis Codes*	Wound Size (sq cm)	Has this wound received a skin substitute in the last 12 months?
Wound 1			<input type="checkbox"/> Yes <input type="checkbox"/> No
Wound 2			<input type="checkbox"/> Yes <input type="checkbox"/> No

For additional wounds, please submit another intake.

Place of Service*

☐ Physician Office (POS 11) ☐ HOPD/CAH (POS 22)
☐ Patient Home (POS 12) ☐ Surgery Center (POS 24)
☐ Assisted Living (POS 13) ☐ Nursing Facility (POS 32)

HIPAA Authorization

By submitting this form you certify that you 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.

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

Fax this form and materials¹ to Reimbursement Services: 337-205-3599
¹Please fax system face sheet, insurance cards (front & back), and supporting clinical notes with this form.
 If Commercial/Medicare Advantage/Medicaid/Managed Medicaid fax 4 weeks of clinical notes.

Notice: Incomplete forms may lead to processing delays. Prior use of skin substitutes or global periods related to the same wound may impact reimbursement.

Reimbursement Info

☎ 888-494-4441

📠 337-205-3599

MKT-020, Rev. 18