

tidesmedical® Benefits Verification Form

Agent Name: _____ Agent Email: _____

Type of Insurance Requested

New patient Re-verification New insurance 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? Yes 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
Facility Contact Name	Phone		<input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Portal
Email Address	Fax		

Product & Treatment Information

Product*	<input type="checkbox"/> APPLICOR 3D®	<input type="checkbox"/> Artacent AC®	<input type="checkbox"/> Artacent Vericlen®	<input type="checkbox"/> Artacent Wound®	Anticipated Application Date:
	<input type="checkbox"/> Biovance®	<input type="checkbox"/> MLG Complete™	<input type="checkbox"/> Other: _____		
	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