

Agent Name: \_\_\_\_\_ Agent Email: \_\_\_\_\_

PROVIDER INFORMATION			
Provider Name		Provider NPI	
Practice Name		Practice NPI	Practice Tax ID
Address, City, State Zip			
Office Contact Name		Phone	Fax
Office Contact Email			Preferred Contact Method <input type="checkbox"/> Fax <input type="checkbox"/> Email
TREATING FACILITY (IF DIFFERENT FROM ABOVE)			
Facility Name			
Phone	Fax	NPI	Tax ID
Address, City, State Zip			
PATIENT INFORMATION (*NAME AND DOB REQUIRED)			
Patient Name*		Phone	Date of Birth*
Address, City, State Zip			
INSURANCE INFORMATION (PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARDS)			
Primary Insurance		Member ID	Phone
Secondary Insurance		Member ID	Phone
TREATMENT INFORMATION			
Product *REQUIRED: <input type="checkbox"/> Artacent Wound <sup>®</sup> <input type="checkbox"/> Artacent AC <sup>®</sup> <input type="checkbox"/> Biovance <sup>®</sup>		Graft Application	
Diagnosis Codes *REQUIRED		Wound Size (sq cm)	
Wound 1			
Wound 2			
Place of Service *REQUIRED		<input type="checkbox"/> 15271: Application of graft to trunk, arms, legs, total wound surface area up to 100cm <sup>2</sup> ; First 25cm <sup>2</sup> wound surface area or less <input type="checkbox"/> 15273: Application of graft to trunk, arms, legs, total wound surface area greater than or equal to 100cm <sup>2</sup> ; First 100cm <sup>2</sup> wound surface area <input type="checkbox"/> 15275: Application of graft to face, scalp, feet, etc. total wound surface area up to 100cm <sup>2</sup> ; First 25cm <sup>2</sup> wound surface area or less <input type="checkbox"/> 15277: Application of graft to face, scalp, feet, etc. total wound surface area greater than or equal to 100cm <sup>2</sup> ; First 100cm <sup>2</sup> wound surface area	
<input type="checkbox"/> Physician Office <input type="checkbox"/> Patient Home <input type="checkbox"/> Hospital Outpatient (HOPD)		<input type="checkbox"/> Assisted Living <input type="checkbox"/> Surgery Center <input type="checkbox"/> Nursing Facility <input type="checkbox"/> Other: _____	
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.			
The Tides Medical <sup>®</sup> Hotline is an information service program. Reimbursement and coverage results are based on the information provided to Tides Medical <sup>®</sup> from the third party payer. Coverage and 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			