tidesmedical® Digital Patient Intake Form

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

Agent Name: _____ Agent Email: _____

TYPE OF INSURANCE VERIFICATION REQUESTED

☐ New patient ☐ New wound ☐ Re-verification ☐ New insurance ☐ Additional applications ☐ Different product

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 ☐ Fax ☐ Email

TREATING FACILITY (IF DIFFERENT FROM ABOVE)

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

PATIENT INFORMATION (*NAME AND DOB REQUIRED) List the patient's name on this form when attaching a face sheet.

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

Is the patient currently residing in a skilled nursing facility? ☐ Yes ☐ No

INSURANCE INFORMATION (PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE CARDS)*

Primary Insurance	Member ID	Phone
Secondary Insurance	Member ID	Phone

TREATMENT INFORMATION

Has the patient received any skin substitutes in the last 12 months? ☐ Yes ☐ No

Product *REQUIRED: ☐ Artacent AC® ☐ Biovance® ☐ Helicoll® ☐ MLG Complete™

	Diagnosis Codes *REQUIRED	Wound Size (sq cm)
Wound 1		
Wound 2		

Place of Service *REQUIRED

☐ Physician Office
☐ Patient Home
☐ Hospital Outpatient (HOPD)
☐ Assisted Living
☐ Surgery Center
☐ Nursing Facility
☐ Other: _____

Graft Application

☐ 15271: Application of graft to trunk, arms, legs, total wound surface area up to 100cm²; First 25cm² wound surface area or less

☐ 15273: Application of graft to trunk, arms, legs, total wound surface area greater than or equal to 100cm²; First 100cm² wound surface area

☐ 15275: Application of graft to face, scalp, feet, etc. total wound surface area up to 100cm²; First 25cm² wound surface area or less

☐ 15277: Application of graft to face, scalp, feet, etc. total wound surface area greater than or equal to 100cm²; First 100cm² wound surface area

Note: Prior use of skin substitutes or global periods related to the same wound may impact reimbursement.

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® 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 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

Incomplete forms may lead to processing delays