

LifeNet Health Benefit Verification Request Form

Program hours are 8 AM - 5 PM ET

Toll-Free HIPM-Compliant Fax: **844-444-0661**

Reimbursement Hotline: **888-982-1080**

Territory Manager: _____

New Wound Re-verification Additional Visits

Product HCPCS Q4121 **TheraSkin** Q4201 **Matrion** Q4122 **Dermacell Porous** Q4122 **Dermacell AWM**

PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Is the patient currently in a SNF? No Yes Days _____

Name and Phone # of SNF: _____

PATIENT WOUND INFORMATION

Wound type and size: Diabetic Foot Ulcer _____ cm² Venous Leg Ulcer _____ cm² Pressure Ulcer _____ cm²
 Dehisced Surgical Wound _____ cm² Necrotizing Fasciitis _____ cm² Traumatic Burn _____ cm²
 Radiation Burn _____ cm² Non-Healing Surgical Wound _____ cm² Mohs _____ cm²
 Traumatic Wound _____ cm² Non-Pressure Wound _____ cm² Other _____

Wound Status(es): Not healing with standard wound care Clean and free of infection

Failed treatment with another skin substitute within 12 months

If so, list products used and how many previous applications _____

Application CPT(s): Trunk/Arms/Legs/Etc. 15271 (1st 25 cm²) 15272 (add'l 25 cm²) 15273 (1st 100 cm²) 15274 (add'l 100 cm²)

Face/Hands/Feet/Etc. 15275 (1st 25 cm²) 15276 (add'l 25 cm²) 15277 (1st 100 cm²) 15278 (add'l 100 cm²)

ICD-10 Diagnosis Code: Primary: _____ Secondary: _____ Others: _____

PATIENT INSURANCE INFORMATION* Please include a front and back copy of patient's insurance card(s)

Primary Insurance Information

Participating Status In-Network Out-of-Network

Insurance Name _____

Policy Number _____

Payer Phone Number _____

Primary Insurance Information

Participating Status In-Network Out-of-Network

Insurance Name _____

Policy Number _____

Payer Phone Number _____

*Some insurances may require a preauthorization: a request for clinical note will be sent, if necessary.

PATIENT/FACILITY INFORMATION

Office (POS 11) Outpatient Hospital (POS 22) Ambulatory Surgical Center (POS 24) Other: _____

Physician Name: _____

Physician

Facility

Facility Name: _____

NPI: _____

Servicing Address: _____

Tax ID: _____

City, State, Zip: _____

PTAN (optional): _____

PHYSICIAN CONTACT INFORMATION

Contact Name: _____

Email: _____

Phone Number: _____

Fax Number: _____

PHYSICIAN DECLARATION

By signing below, I certify that I have received patient authorization to release the medical and/or other patient information for the above referenced patient.

Physician or Authorized Signature: _____ Date: _____

Disclaimer: LifeNet Health Reimbursement Hotline is an informational service only and not a guarantee of reimbursement. Benefit Verifications are performed based on information provided by the customer and the patient's insurer or third-party payer. Any decisions regarding appropriate coding, billing, and policy guidelines such as frequency limitations and medical necessity are the sole responsibility of the provider of service. Coverage determinations are based on patient eligibility, plan benefits, provider contracts, and medical policy at the time of claim processing. Verifications of benefits and prior authorization approvals are not guarantees of insurance payment. Any decisions regarding appropriate coding, billing, and policy guidelines such as frequency limitations and documentation of medical necessity are the sole responsibility of the provider of service.

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EX-2326.03

