Osiris THERAPEUTICS, INC. is now part of Smith+Nephew

Smith+Nephew Reimbursement Hotline Services
Insurance Verification Request (IVR) Form
Phone: 866-988-3491 **Fax:** 866-304-6692

1.Type of Insurance Verification Requested

☐ New Wound ☐ Additional Applications ☐ Re-Verification ☐ New Insurance ☐ Check Out-Of-Pocket Maximum

If a prior authorization is required, I authorize Smith and Nephew to initiate the authorization. **Please select one:** ☐ **Yes** ☐ **No**
***If yes**, please attach all clinical notes related to the wound treatment episode.*

2. Patient Information: *Please list the patient's name on this form when attaching a face sheet*

First Name:	Last Name:			M.I.:
Address:	Apt./Suite#:	City:	State:	Zip:
Date of Birth:	Gender: ☐ Female ☐ Male	Phone #:		

3. Insurance Information: *Please attach a copy (Front & back) of patient's insurance card(s)*

Cardholder Name/Relationship:		Date of Birth:
Primary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:
Secondary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:
Tertiary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:

4. Healthcare Provider (HCP) & Facility Information: *Please note, we do not verify inpatient benefits*

Place of Service: ☐ Physician Office (POS11) ☐ Hospital Outpatient Department (POS19/22) ☐ Ambulatory Surgery Center (POS24)

Is the patient currently in a SNF? (POS31/32): ☐ Yes or ☐ No ***If yes,*** ☐ Under 100 days *or* ☐ Over 100 Days ☐ Other POS: _____

SNF Name:	Contact Name:	SNF Phone#:	
HCP First Name:	HCP Last Name:		M.I.:
HCP NPI:	HCP Tax ID#:	HCP PTAN#:	
Specialty: ☐ MD ☐ DO ☐ DPM ☐ PA ☐ NP/FNP ☐ Other: _____		HCP Payer ID/Medicaid PIN:	
Contact Name:	Phone #:	HCP Network Status: ☐ In ☐ Out	
Facility Name:		Facility Network Status: ☐ In ☐ Out	
Facility Address:	Facility NPI:	Phone #:	
City, State, Zip:	Facility Tax ID:	Fax #:	
Managing Facility Address (if different):		MAC/Fiscal Intermediary:	
Third Party Administrator/Biller:			

5. Treatment Information: *May select up to FOUR products with corresponding CPT application code groups*

☐ **GRAFIX PL PRIME◇ (Q4133)** ☐ **GRAFIX PRIME◇ (Q4133)** ☐ **GRAFIX CORE◇ (Q4132)**

☐ **OASIS® Wound Matrix (Q4102)** ☐ **OASIS® Burn Matrix (Q4103)** ☐ **OASIS® ULTRA Tri-Layer Matrix (Q4124)**

CPT:
Legs/Arms/Trunk ≤ 100 sq cm: ☐ 15271/15272-C5271/C5272 **Legs/Arms/Trunk ≥ 100 sq cm:** ☐ 15273/15274-C5273/C5274
Feet/Hands/Head ≤ 100 sq cm: ☐ 15275/15276-C5275/C5276 **Feet/Hands/Head ≥ 100 sq cm:** ☐ 15277/15278-C5277/C5278

Anticipated Application Date: _____ **Number of Anticipated Applications:** _____

6. Wound Information & Diagnosis Code(s): *Provide the ICD-10-CM Code(s) for the treatment condition below*

☐ **Diabetic Ulcer** (Code Diabetes ***and*** Ulcer Location Separately)**:** _____, _____ ☐ **Burn:** _____, _____

☐ **Venous Ulcer**: _____, _____ ☐ **Surgical Dehiscence:** _____, _____ ☐ **Other:** _____, _____

☐ **Pressure Ulcer:** _____, _____ ☐ **Trauma Wound:** _____, _____

7. Healthcare Provider Signature: *Please include all required information and sign below*

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form permitting me to release the patient's protected health information (PHI) to the Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to GRAFIX PL◇/GRAFIX◇ and/or OASIS® Matrix products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge.
For typed signatures below: I agree that this typed signature has the same validity and meaning as my handwritten signature.

HCP Signature: _____ **Date:** _____

Disclaimer: The Smith+Nephew Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Smith & Nephew disclaims liability for payment of any claims, benefits or costs.

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Instructions on Completing the Insurance Verification Request Form (IVR): *Please see below*

Step 1: The IVR form must be completed by the provider/provider staff and submitted by the account/office. Please complete and sign the IVR form in its entirety and refer to the required information below to minimize processing delays.
Step 2: Fax the completed IVR to the fax number listed above.
Step 3: There is a 48-hour turnaround time for complete forms received. Please ensure all applicable fields are completed prior to faxing.

1. Type of Insurance Verification Requested: *Check the box for one of the following:*

New Wound: When a new episode of treatment begins for a new wound.
Additional Applications: When more than the originally requested quantity is needed or requires additional authorization.
Re-Verification: When a re-verification is needed during the current episode of treatment or a new benefit year with the same insurance begins.
New Insurance: When a new insurance has been identified for an existing S+N patient undergoing treatment and requires investigation.
Check Out-Of-Pocket Maximum: When an out-of-pocket maximum check is needed for an existing S+N patient undergoing treatment.
If you would like assistance with initiating and tracking prior authorizations, please check the Prior Authorization "Yes" box and provide all pertinent clinical documentation. Note: Instructions will be reported on the results form, please be sure to review instructions carefully.

2. Patient Information: *Please list the patients name on the form when attaching a face sheet*

Patient demographics are **required** for the completion of the patient Insurance Verification Request.
Option 1: Complete all patient information in section 2 in its entirety.
Option 2: Indicate the patient name on the IVR form and include a copy of the patient face sheet that provides the patient demographics.

3. Insurance Information: *Please attach a copy (front & back) of patient's insurance card(s)*

Patient insurance information is **required** to research benefits. Please indicate all active policy information. Please provide a copy of the patient's insurance card(s) when possible (front *and* back). Note: For Workman's Compensation please include date of injury and claim adjuster contact information. For Veterans Administration insurance please include the local Veterans Affairs facility affiliation.

4. Healthcare Provider (HCP) & Facility Information: *Please note, we do not verify inpatient benefits*

Physician Office (POS11): Select when your place of service is physician owned.
Hospital Outpatient Department (POS19/22): Select when your place of service is hospital owned under 19-Off Campus or 22-On Campus.
Ambulatory Surgery Center (POS24): Select when your place of service is a hospital owned ASC. See POS11 when applicable.
Skilled Nursing Facility (POS31/32): Select when the patient resides in a SNF/Nursing Facility ***and*** confirm length of stay. Please also include SNF name and contact information as necessary.
Other POS: If selected, please state place of service or type. For Example: 12 or Home, CAH (Critical Access Hospital)
Healthcare Provider Information is required for completion of the patient Insurance Verification Request. Please list all pertinent credential information as listed on the form including National Provider Identification (NPI), Tax ID, Patient Transaction Access Number (PTAN), and Payer ID/ Medicare PIN which allows for communication with associated payers and appropriate collection of network status.
Facility Information is also required for completion of the patient Insurance Verification Request. Please list all pertinent credential information as listed on the form. Please include (when applicable) if a Managing Facility is used to bill claims and note Medicare Administrative Contractor/Fiscal Intermediary if different than that assigned to the listed physical address for treatment as this can affect the benefit investigation.
Third Party Administrator/Biller: Please include this information if a third party is submitting requests on your behalf for proper communication contact.

5. Treatment Information: *May select up to four products and corresponding CPT application code(s)*

Treatment Information is required. Please indicate product choice(s) and complete the Anticipated Application Date ***with*** Number of Anticipated Applications. This information may be provided to the payer during benefit investigation and may affect benefit investigation results. Please consider the total wound surface area and anatomical site(s) when selecting the corresponding Current Procedural Terminology (CPT) code(s).

6.Wound Information & Diagnosis Code(s): *Provide the ICD-10-CM Code(s) for the treatment condition below*

Wound Information & Diagnosis Code(s) are required. Please utilize correct coding practices for ICD-10-CM and code to the highest level of specificity whenever possible. Please review for etiology (disease condition) and anatomical location - Ex: Code diabetes or venous insufficiency ***and*** ulcer location separately. *Note: Use of unspecified and/or not otherwise specified codes may result in delayed benefit investigation results. Please consider review of specific payer policies for additional information whenever possible.*

7. Healthcare Provider Signature: *Please include all required information and sign below*

Healthcare Provider Signature is required. This serves as certification that the provider has obtained valid authorization from the patient listed on this form permitting release of the patient's protected health information (PHI) to Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to GRAFIX PL◇/GRAFIX◇ and/or OASIS® Matrix products on behalf of the patient. This further certifies that the HCP understands that by completing this form, it does not guarantee that insurance coverage or reimbursement will be provided.

Questions? The Smith+Nephew Reimbursement Hotline is available Monday-Friday between the hours of 8:00 am and 7:00 pm ET at 1-866-988-3491.

Oasis Matrix Products manufactured by:
Cook Biotech, Inc.
1425 Innovation Place
West Lafayette, IN 47906

Distributed by:
Advanced Wound Management
Smith & Nephew, Inc.
Fort Worth, TX 76109
USA

www.smith-nephew.com
www.oasiswoundmatrix.com
www.osiris.com