Fax Completed Form To:
844-529-3247
Hotline Phone : **844-KERECIS**
(844-537-3247)
ReimbursementUS@kerecis.com

Benefit Investigation Request Form: Kerecis™ Omega3 Wound

Representative Name: ____________________

Patient Information

Name: ____________________

Date of Birth: ____________________

ICD-10 DX 1. ____ 2. ____ 3. ____ 4. ____ 5. ____

- Is the patient currently residing in a nursing home or skilled nursing facility? Yes No
- Is the patient currently in a surgical global period? Yes No
- If yes, please indicate the date of the of the surgical procedure: ____________________
- The patient is scheduled to receive application of graft on: ____________________
- Patients wound size (total sq. cm.) ____________________

Insurance Information

PRIMARY INSURANCE

Name: ____________________

Policy ID: ____________________

Group # ____________________

Contact Phone: ____________________

SECONDARY INSURANCE

Name: ____________________

Policy ID: ____________________

Group # ____________________

Contact Phone: ____________________

Tertiary Insurance

Name: ____________________

Policy ID: ____________________

Contact Phone: ____________________

If Prior Authorization is required would you like the Kerecis Reimbursement Hotline to initiate the request on your behalf?

☐ **YES** ☐ **NO**

Physician Information

Name: ____________________

Address: ____________________

NPI: ____________________

Tax-ID: ____________________

PTAN: ____________________

Phone: ____________________

Fax: ________ / ____________

Contact Person: ____________________

Facility Information

Name: ____________________

Address: ____________________

NPI: ____________________

Tax-ID: ____________________

PTAN: ____________________

Phone: ____________________

Fax: ________ / ____________

Contact Person: ____________________

Place of Service:

☐ **Physician Office 11** ☐ **Hospital Outpatient 22** ☐ **FreestandingASC 24**

Other: ____________________

I certify that I have received the required patient consent to release medical records and patient-specific information to Kerecis and its affiliates:

Physician Signature

____

Date:

____