Benefit Investigation Request Form: Kerecis® Omega3 Wound

Fax Completed Form To:
FAX: 844-529-3247
Hotline Phone : 844-KERECIS
(844-537-3247)

Kerecis Representative Name: _____

Patient Information

Name: _____ Date of Birth: _____
Patient Address _____
City/State/Zip _____ Patient Phone: _____
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 and CPT code of surgical procedure: DATE: _____ CPT CODE: _____
- The patient is scheduled to receive application of graft on: _____
- Total wound size (combined area of all wounds treated) _____

Insurance Information (Attach copy of card)

PRIMARY INSURANCE
Name: _____
Policy ID: _____
Group # _____
Contact Phone: _____

SECONDARY INSURANCE
Name: _____
Policy ID: _____
Group # _____
Contact Phone: _____

TERTIARY INSURANCE OR WORKERS COMP CLAIMS
Name / Adjustor Name _____
Policy ID/Claim # _____
Contact Phone _____ Date of Injury: _____

If Prior Authorization is required would you like the Kerecis Reimbursement Hotline to initiate the request on your behalf? ☐ YES ☐ NO
If YES, please provide at least 3 weeks of progress notes and pertinent lab work.

Physician Name _____

Medical Specialty: _____
Address: _____
City/State/Zip: _____
Billing NPI: _____
Billing Tax-ID: _____
Medicare PTAN: _____
Phone: _____
Fax: _____
Contact Person: _____

Facility Name _____

Department: _____
Address: _____
City/State/Zip: _____
Group NPI: _____
Group Tax-ID: _____
Medicare PTAN: _____
Phone: _____
FAX: _____
Contact Person: _____

Place of Service: ☐ Physician Office 11 ☐ Hospital Outpatient 22 ☐ Freestanding ASC 24

Other _____

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

Physician Signature (required) _____ **Date** _____

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