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 **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.***	**Single Wound** **Multiple Wounds**	**Application Date:** ____/ _____/ _____

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)

Home Visit (POS12) Assisted Living Facility (POS13) Unskilled Nursing Bed (POS32) Other POS: __________

NOTE: Select only ONE POS. It is the provider's responsibility to confirm POS and skilled vs. unskilled status

HCP First Name:	HCP Last Name:	M.I.:
HCP NPI:	HCP Tax ID#:	Specialty: ☐ MD ☐ DO ☐ DPM ☐ PA
Contact Name:	Phone #:	☐ NP/FNP ☐ Other: ______
Facility Name:		Facility NPI:
Facility Address:		Facility Tax ID:
City, State, Zip:	Phone #:	Fax #:

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)** **GRAFIX PLUS◊ (Q4304)**

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

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

6. Wound Information & Diagnosis Code(s): *Please include codes that indicate etiology, ulcer type, AND location*

ICD-10 Codes: #1 Wound (Required)	**ICD-10 Codes: #2 Wound (*Required)**	**ICD-10 Codes: #3 Wound (*Required)**
Primary (Etiology): ___________	Primary (Etiology): ___________	Primary (Etiology): ___________
Secondary (Ulcer/Location): ___________	Secondary (Ulcer/Location): ___________	Secondary (Ulcer/Location): ___________
Tertiary (Optional): ___________	Tertiary (Optional): ___________	Tertiary (Optional): ___________
Wound #1 Size: L _____ W _____ D_____	**Wound #2 Size:** L _____ W _____ D ______	**Wound #3 Size:** L _____ W _____ D ______

***If intending to treat more than one wound, please provide diagnosis codes for each additional 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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Insurance Verification Request (IVR) Form
Phone: 866-988-3491 **Fax:** 866-304-6692

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.
Prior Authorization: Please indicate if you would like assistance by checking Yes or No.
Single or Multiple Wounds: Please select if this IVR will include one or more wounds for the same patient. Please limit to up to 3 wounds per patient per IVR form, and be sure to include separate ICD-10 codes and Wound Size for each wound.
Application Date: Please state the anticipated application date to assist with expediting urgent cases, or holding for reverifications.

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.
Home Care (POS12): Select when your place of service is a patient's home.
Assisted Living Facility (POS13): Select when your place of service is an assisted living facility.
Unskilled Nursing Bed (POS32): Select when the patient resides in a Nursing Facility and is NOT under a skilled stay (generally > 100 days).
Other POS: If selected, please state place of service or type. For Example: 13 (Assisted Living Facility), 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.
Facility Information is also required for completion of the patient Insurance Verification Request. Please list all pertinent credential information as listed on the form.

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

Treatment Information is required. Please indicate product and CPT code choice(s). Please note, prior use of skin substitutes or global periods related to the same wound may impact reimbursement.

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. Please also list the Wound Size for each wound related to this IVR. *Note: Use of unspecified and/or not otherwise specified codes may result in delayed benefit investigation results.*

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

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