NextGen Wound Care
— HEALING WOUNDS HEALING LIVES —

NextGen Wound Care provides insurance verification to its customers through an independent, HIPAA compliant, third-party.
Protected Health Information (PHI) is not collected by RevoGen. Third-party service provider is direct recipient of all PHI.

Insurance Verification Request Form

Please fax or call our dedicated IVR support team:
Fax: (844) 763-0255 | **Phone:** (844) 409-0062

Required information indicated by *

☐ New Wound ☐ Additional Application ☐ Re-verification ☐ New Insurance

PATIENT AND INSURANCE INFORMATION

*Patient Name:		*DOB:		☐ Male ☐ Female	
Address:		City:		State:	Zip:
Home Phone #:		Mobile #:			

*Is this patient currently in a skilled facility or nursing home? ☐ Yes ☐ No
If YES, how many days has the patient been admitted to the skilled nursing facility or nursing home?

Primary Insurance:		Secondary Insurance:	
Payer Phone #:		Payer Phone #:	
Policy Number:		Policy Number:	
Subscriber Name:		Subscriber Name:	

PROVIDER AND FACILITY INFORMATION

*Provider Name:		Specialty:		PTAN#:	
Provider ID #s:NPI:		Tax ID:		Medicaid Provider #:	
*Facility Name:					
Address:		City:		State:	Zip:
Facility ID #s:NPI:		Tax ID:		PTAN#:	
*Facility Contact:		Phone #:		Fax #:	
Email Address:					

*Treatment Setting ☐ Hospital Based Outpatient Wound Department/Clinic (HOPD) ☐ Provider's Office

CODING AND BILLING

☐ Q4188 AmnioArmor® Dual Layer Amnion Patch

☐ Diabetes ☐ Vascular ☐ Other	☐ 20550 ☐ 20551 ☐ 20552
☐ 15271 ☐ 15275 ☐ Other, please specify	☐ 20553 ☐ 28899 ☐ Other, please specify:
*ICD-10 Diagnosis Codes (Related to AmnioArmor® Dual Layer Amnion Patch treatment)	Primary Secondary Tertiary
	Known Conditions: Wound Size:

Anticipated Treatment Start Date:		Frequency:		Number of Applications:	

If the payer requires prior authorization for the predetermination for NextGen Wound Care product applications, would you like assistance?
☐ Yes ☐ No If yes, please attach a minimum of four weeks of clinical notes

I certify that I have obtained a valid authorization under applicable law from the patient listed on this form (a) permitting me to release the patient's protected health information (PHI), for the purpose of insurance verification; and (b) authorizing the payer to disclose PHI to an independent, HIPAA compliant, third-party service provider for the purposes of determining benefit coverage.

Provider Signature: _____ **Date:** _____ **Sales Representative:** _____

Please fax this form along with a copy of the front and back of the patient's insurance card.

Disclaimer: Insurance verification is an information service only. Information gathered during the requested research will be provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement, or payment of any claims, benefits, or costs.