Find this form on myportal for easier submissions!

tidesmedical® Benefits Verification Form

Agent Name: _____ Agent Email: _____

TYPE OF INSURANCE VERIFICATION REQUESTED

☐ New patient ☐ New wound ☐ Re-verification ☐ New insurance ☐ Additional applications ☐ Different product

PATIENT & INSURANCE INFORMATION (*NAME AND DOB REQUIRED) List the patient's name on this form when attaching a face sheet.

Patient Name*		Date of Birth	
Address	City	State	ZIP
Is the patient currently residing in a skilled nursing facility and receiving Part A benefits? ☐ Yes ☐ No			
Primary Insurance	Member ID	Phone	
Secondary Insurance	Member ID	Phone	

PROVIDER & FACILITY INFORMATION

Provider Name*	Provider Tax ID		
Provider NPI	PTAN#		
Facility Name			
Address	City	State	ZIP
Facility NPI	Facility Tax ID	Facility PTAN#	
Phone	Fax	Preferred Contact Method ☐ Fax ☐ Email ☐ Portal	
Facility Contact Name	Phone		
Email Address	Fax		

PRODUCT & TREATMENT INFORMATION

Product *REQUIRED: ☐ Artacent AC® ☐ Biovance® ☐ Helicoll® ☐ MLG Complete™

Anticipated Application Date	Number of Anticipated Applications

	Diagnosis Codes *REQUIRED	Wound Size (sq cm)	Has this wound received a skin substitute in the last 12 months?
Wound 1			☐ Yes ☐ No
Wound 2			☐ Yes ☐ No

For additional wounds, please submit another intake.

Place of Service *REQUIRED

☐ Physician Office (POS 11) ☐ HOPD/CAH (POS 22) ☐ Surgery Center (POS 24)
☐ Patient Home (POS 12) ☐ Assisted Living (POS 13) ☐ Nursing Facility (POS 32)

Please submit this form along with a copy of the patient's insurance card (front/back) and any supporting clinical notes.
Note: Prior use of skin substitutes or global periods related to the same wound may impact reimbursement.

HIPAA AUTHORIZATION

By submitting this form you certify that you have received the necessary patient consent to release the medical and/or other patient information referenced on this form to Tides Medical for the purpose of using and re-disclosing this information, as necessary, for insurance verification, prior authorization, and/or claims support.

Reimbursement and coverage results are based on the information provided to Tides Medical® from the third party payer. Coverage and reimbursement are subject to change at any time. Benefits Verification results from the Tides Medical information service program are not a guarantee of coverage and payment now or in the future.

Fax this form to Reimbursement Services: 337-205-3599
Incomplete forms may lead to processing delays

Reimbursement Info
888-494-4441
337-205-3599