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tidesmedical® Benefits Verification Form

Agent Name: _____ Agent Email: _____

Type of Insurance Requested

☐ New patient ☐ Re-verification ☐ New insurance ☐ Additional applications

Patient & Insurance Information

*Name & DOB required. List 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

Is the patient currently in a surgical global period? ☐ 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* ☐ APLICOR 3D® ☐ Artacent AC® ☐ Artacent Vericlen® ☐ Artacent Wound® ☐ Biovance® ☐ MLG Complete™

Anticipated Application Date

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

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 guarantee of coverage and payment now or in the future.

Fax this form and materials[1] to Reimbursement Services: 337-205-3599

[1]Please fax system face sheet, insurance cards (front & back), and supporting clinical notes with this form. If Commercial/Medicare Advantage/Medicaid/Managed Medicaid fax 4 weeks of clinical notes.

Notice: Incomplete forms may lead to processing delays. Prior use of skin substitites or global periods related to the same wound may impact reimbursement.

Reimbursement Info

888-494-4441

337-205-3599