WORLD REACH HEALTH

# AMNIOBIND ALLOGRAFT ORDER FORM

Email completed form to sales@worldreachhealth.com

## ACCOUNT REPRESENTATIVE

REP NAME: **Kimberley O'Sullivan** DATE: _____

REP EMAIL: **KOMSDConsult@gmail.com** CELL: **781-366-4600**

## PROVIDER'S BILLING INFORMATION

CLINIC NAME: _____

PHYSICIAN NAME: _____

NPI #: _____

BILLING ADDRESS: _____

CONTACT PERSON: _____

EMAIL: _____

PHONE: _____

CHECK IF SIGNATURE IS ON FILE

## SHIPPING INFORMATION

CHECK IF SAME AS BILLING INFO

CLINIC NAME: _____

SHIPPING ADDRESS: _____

_____

CONTACT PERSON: _____

EMAIL: _____

PHONE: _____

OVERNIGHT SHIPPING REQUESTED

| AmnioBind Allograft | Total $CM^2$ | Sizing & Pricing | |
|---|---|---|---|
| SIZE | TOTAL $CM^2$ | PRICE PER $CM^2$ | UNIT PRICE |
| 2.0CM X 2.0CM | $4CM^2$ | $1,450 | $5,800 |
| 3.0CM X 3.0CM | $9CM^2$ | $1,450 | $13,050 |
| 4.0CM X 4.0CM | $16CM^2$ | $1,450 | $23,200 |
| 6.5CM X 6.5CM | $43CM^2$ | $1,450 | $62,350 |

## ORDERING INSTRUCTIONS

- Email completed form to sales@worldreachhealth.com
- Orders received prior to 2pm MST may be eligible for same day shipping
- Orders will be shipped via ground transportation (included), allow 2 days for delivery
- If expedited (overnight) shipping is requested additional fees may apply
- Available products will be confirmed by email and ship within one business day

| | | | | Allograft Size & Quantity | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| # | Patient Name | Wound Location | IVR Approval # | 2.0 x 2.0 | 3.0 x 3.0 | 4.0 x 4.0 | 6.5 x 6.5 | Total $CM^2$ | Week # |
| | | | | | | | | | |
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| | | | | | | | | | |
| | | | TOTAL | | | | | | |

TOTAL SQCM

INTERNAL USE ONLY

DATE ORDERED

**World Reach Health, LLC**
Tel: 847-220-4664
Fax: 847-463-0554
Email: sales@worldreachhealth.com
Web: www.WorldReachHealth.com
3501 W. Algonquin Rd, Suite 135
Rolling Meadows, IL 60008

WORLD REACH HEALTH

# HealthTech Wound Care Patient Support Program Patient Insurance Verification Form

**3 Ways to Submit IVR Request Form:**

- ☐ **Fax completed form to: 833.717.2940**
- ☐ **Upload this form via your dedicated portal**
- ☐ **Email Form: reimbursement@healthtechwc.com**

Account Representative Name: **Kimberley O'Sullivan**

Contact Email: **kosmdconsult@gmail.com**

Phone Number: **781-366-4600**

☐ **AmnioBind - Q4225** ☐ **DermaBind SL - Q4284**

## TYPE OF INSURANCE VERIFICATION REQUEST

Please select one: ☐ New Application ☐ Prior Authorization ☐ Additional Applications ☐ Re-verification ☐ Appeal/Denial Request (Please provide EOBs and denial documentaion.)

## PATIENT INFORMATION:

*Please submit copies of insurance cards (front & back) and patient demographics sheet. *Provide Medical Record Number (MRN) if available.*

| | | | |
|---|---|---|---|
| Patient Name: | | | DOB: |
| Address: | | | MRN: |
| City: | State: | | Zip Code: |
| Primary Ins: | Ins ID#: | Group #: | Ins. Phone: |
| Secondary Ins: | Ins ID#: | Group #: | Ins. Phone: |
| Is patient currently in a surgical global period? ☐ Yes ☐ No | If yes, what is the CPT surgery code? | | Surgery Date? |
| Is patient currently residing in a nursing home or any in-patient facility? ☐ Yes ☐ No | *Reminder: Q Codes not separately payable while patient under part A episode of care.* | | |

## PROVIDER INFORMATION:

Place of Service: ☐ Physician Office (11) ☐ Home (POS 12) ☐ Nursing Facility (POS 32) ☐ Ambulatory Surgical Center (24) ☐ HOPD (22) ☐ Other: Please List Place of Service (CAH, SNF): _____

| | | |
|---|---|---|
| Rendering Physician Name: | | |
| NPI: | TIN: | Medicare PTAN: |
| Address: | | Provider Phone: |
| City: | State: | Provider Fax: |
| Primary Contact Person: | | Contact Phone: |
| Contact Email Address: | | Contact Fax: |

## FACILITY INFORMATION:

| | | |
|---|---|---|
| Facility Name: | Facility Phone: | Facility Fax: |
| Facility Address: | | |
| Facility NPI: | Facility TIN: | Medicare PTAN (Group): |
| Primary Contact Person: | | Contact Phone: |
| Contact Email Address: | | Contact Fax: |

## PROCEDURE INFORMATION:

*Please attach all supporting clinical documentation such as treatment plan, progress notes, and LOMN.

| | | |
|---|---|---|
| Anticipated Treatment Start Date: | Wound Location: | Wound Size: |
| Diagnosis ICD-10 Codes: | | |
| ☐ Diabetic Foot Ulcer ☐ Venous Leg Ulcer ☐ Lower Extremity Chronic Ulcer ☐ Other: _____ | | |
| Number of Grafts: | Size of Initial Graft (in sq.cm): | |
| Additional Clinical Comments: | | |
| Physician Signature: | | ☐ Physician Signature on file |

*The signature above certifies that the physician has the necessary patient authorization to release the medical and/or patient information to COMPANY, its contractors and the patient's health insurance company as necessary to research insurance coverage and determine benefits related to COMPANY products.*
*COVERAGE, REIMBURSEMENT AND/OR BENEFIT VERIFICATION FOR ANY PRODUCT OR PROCEDURE CANNOT BE GUARANTEED, AND THE COMPANY REIMBURSEMENT HOTLINE AND COMPANY DISCLAIM LIABILITY FOR PAYMENT OR NONPAYMENT OF ANY CLAIMS, BENEFITS OR COSTS. THIRD-PARTY PAYMENT FOR MEDICAL PRODUCTS AND SERVICES IS AFFECTED BY NUMEROUS FACTORS. IT IS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES AND MODIFIERS FOR SERVICES RENDERED.*