AmnioBand® ALLOGRAFT PLACENTAL MATRIX MEMBRANE

AmnioBand® ALLOGRAFT PLACENTAL MATRIX VIABLE MEMBRANE

AmnioBand® ALLOGRAFT PLACENTAL MATRIX PARTICULATE

AlloPatch® ALLOGRAFT DERMAL MATRIX PLIABLE

☐Q4151 ☐Q4168 ☐Q4128

# Patient Information and Precertification

Physicians and healthcare providers may be required to precertify services with a patient's insurance company. In the event precertification is required, the following form may serve as a template. If you need assistance in obtaining precertification, complete this form and send with a copy of the patient's insurance card and patient authorization signature.

**PLEASE FAX COMPLETED FORM TO (877) 499-2986**

## Patient Information

**Patient Name** | **Date of Birth** | **Phone**

**Address/City/State/Zip**

**Employer** | **Employer Phone**

## Insurance Information

**Primary Insurance** | **Member ID** | **Group ID**

**Subscriber Name** | **Type of Plan (HMO/PPO/Other)** | **Insurance Phone Number**

**Does Provider Participate with Network?** ☐ Yes ☐ No | **Do you have a referral on file?** ☐ Yes ☐ No | **Subscriber's Date of Birth**

**Secondary Insurance** | **Insurance Phone** | **Member ID** **Group ID**

**Subscriber Name** | **Type of Plan (HMO/PPO/Other)** | **Pre-Cert Phone**

**Does Provider Participate with Network?** ☐Yes ☐No | **Do you have a referral on file?** ☐ Yes ☐ No | **Subscriber's Date of Birth**

## Physician Information

**Physician Name** | **Phone** | **NPI**

**Address/City/State/Zip** | **Fax** | **TIN**

**Practice Name** | **Office Contact** | **Contact Email Address:**

## Facility Information

**Name of facility where procedure will be performed** | **Phone** | **NPI**

**Address/City/State/Zip** | **Fax** | **TIN**

## Procedure

**Diagnosis** | **ICD-10** | **Procedure Code (s)**

**Place of Service** ☐ Office ☐ ASC ☐ Outpatient Hospital ☐ Inpatient Hospital | **Procedure Date** | **Wound Care Consultant**

## Patient Consent

**Patient Consent signed and on file** ☐ Yes ☐ No | **Date Signed**

**PLEASE FAX COMPLETED FORM TO PINNACLE AT (877) 499-2986**

**Did you know?** The Pinnacle Health Group provider portal allows you to submit these requests online, no printing or faxing required! To get started, contact The Pinnacle Health Group at (866) 369-9290 for details.

The Pinnacle Health Group assists healthcare professionals with benefit verifications and precertifications by third-party payers based on coverage guidelines provided by the payer and patient information provided by the healthcare provider. Third-party reimbursement is based upon many different factors and Pinnacle make no representation or guarantee that any payment will be made.