FLOWER ORTHOPEDICS™

FLOWERAMNIO™ INSURANCE VERIFICATION REQUEST

Please print and fax to: 267.803.6020
Phone: 800.901.6264

FZE

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

Flower Orthopedics does not verify benefits for procedures performed in the operation room setting

Research Information	**Etiology**
☐ Q4178 Flower AmnioPatch™ ☐ Q4177 Flower AmnioFlo™	☐ Diabetes ☐ Vascular ☐ Other

*ICD-10 Diagnosis Codes (Related to FlowerAmnioPatch treatment)	Primary Secondary Tertiary
	Known Conditions: Wound Size
*Application Codes:	☐15271 ☐15273 ☐15275 ☐15277 ☐ Other, please specify:
Anticipated Treatment Start Date:	Frequency: Number of Applications:

If the payer requires prior authorization for pre-determination for Flower Orthopedics 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), to Flower Orthopedics and its contractors to research insurance coverage regarding FlowerAmnioPatch products, and to provide me with reimbursement assistance services regarding such products; and (b) authorizing the payer to disclose PHI to Flower Orthopedics and its contractors 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: Flower Orthopedics offers insurance verification as 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 in the future. Flower Orthopedics disclaim liability for payment of any claims, benefits, or costs.