

Symphony™
AROA ECM™

Insurance Verification Request

Contact Us: **Aroa Biosurgery Inc.** | **Tel:** 1-800-807-2762 | **Email:** reimbursement@aroa.com | **Fax:** 1-877-775-3157

Office Contact:

Email:

Phone: **Fax:**

Provider/Facility Information

Physician Name:	Facility Name:
NPI:	NPI:
Tax ID:	Tax ID:

Place of service:

- ☐ Physician Office
- ☐ Ambulatory Surgical Center (ASC)
- ☐ Hospital Based Outpatient (HOPD)
- ☐ Other:

ICD-10-CM codes:

Primary:

Secondary:

Tertiary:

Symphony size required:

- ☐ 16 mm disc | 2 cm^2
- ☐ 2 x 2 cm | 4 cm^2
- ☐ 2 x 3 cm | 6 cm^2
- ☐ 4 x 3 cm | 12 cm^2
- ☐ 4 x 4 cm | 16 cm^2
- ☐ 5 x 5 cm | 25 cm^2
- ☐ 10 x 5 cm | 50 cm^2

CPT:

- **Legs/Arms/Trunk < 100 sq cm:** ☐ 15271/15272
- **Feet/Hands/Head < 100 sq cm:** ☐ 15275/15276
- **Legs/Arms/Trunk > 100 sq cm:** ☐ 15273/15274
- **Feet/Hands/Head > 100 sq cm:** ☐ 15277/15278

Pre-Authorization Assistance:

If pre-authorization is required would you like assistance: ☐ Yes ☐ No

If IVR Approved: Fulfillment Method:

- ☐ Order product
- ☐ Consignment
- ☐ Stock

AROA™ Sales Representative:

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Patient Information

Patient Name:	Phone Number::	DOB:
Address:	City:	
	State:	Zip:

A copy of insurance card/s (front and back) have been submitted ☐ Yes ☐ No

Primary Insurance:	**Secondary Insurance:**
Payer Name:	Payer Name:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:

Last chart note submitted and 4 weeks of clinical notes submitted: ☐ Yes ☐ No

Comorbidities:			**Wound Etiology:**	
Patient has Diabetes:	☐ Yes	☐ No	Diabetic Foot Ulcer (DFU)	☐
Is diabetes under control:	☐ Yes	☐ No	Venous leg Ulcer (VLU)	☐
Patient is a smoker:	☐ Yes	☐ No	Pressure Ulcer / Pressure Injury	☐
Does patient have an active infection:	☐ Yes	☐ No	Arterial Ulcer	☐
Wound Information:			Mixed Arterial – Venous Ulcer	☐
Number of wounds treated:			Post-Surgical Wound (Dehisced)	☐
Treatment Start date:			Traumatic Wound (Acute)	☐
Frequency of treatment:			Other:	
Number of applications requested:				
Wound onset date:				
Wound dimensions: Length: Width: Depth:				

Authorization and Agreement

By submitting this form, you certify that a valid authorization has been obtained from the patient that permits a release of the patient's protected health information and insurance information to Aroa Biosurgery Inc., its contractors and the patient's health insurance company as necessary to research insurance coverage (including benefit determination and/or prior approval authorizations) and payment information as it relates to the use of Aroa Biosurgery Inc. products. You also agree to the Business Associate Agreement set out here [https://aroa.com/ivr-baa/] on behalf of the Covered Entity named below.

I acknowledge the disclaimer below and certify that the information provided on this form is current, complete, and accurate to the best of my knowledge.

Signature of qualified healthcare professional: _____ Date: / /

Covered Entity (facility) name: _____

Disclaimer: Aroa Biosurgery Inc. reimbursement assistance is offered as an information support only. Please keep in mind that this information represents a summary of information provided by the insurer or third-party payer. Results of this research is provided "as is" and is not a guarantee of coverage or reimbursement now or in the future. Aroa Biosurgery Inc. disclaims liability for any damages or costs however caused by any reliance on its reimbursement assistance. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered, and for verifying coverage with the patient's insurance carrier.

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