Insurance Verification Request

Symphony™ Proliferative Bioscaffold

AROA™

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

Case Manager:		**Email:**	
Phone:		**Fax:**	

Patient Information

Patient Name:	DOB:	M ☐ F ☐
Address:	City:	Phone Number:
	Zip:	

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

Primary Insurance:	**Secondary Insurance:**
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Pre-authorization Phone Number:	Pre-authorization Phone Number:
If pre-authorization is required would you like assistance: ☐ Yes ☐ No	If pre-authorization is required would you like assistance: ☐ Yes ☐ No
Is provider and facility in network? ☐ Yes ☐ No	Is provider and facility in network? ☐ Yes ☐ No

Last chart note submitted, and if Commercial/Medicare Advantage, 4 weeks of clinical notes submitted: ☐ Yes ☐ No

Provider/Facility Information

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

Place of service:

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

Tx Start Date:

Frequency:

Of Applications:

ICD-10-CM codes:

Primary:

Secondary:

Tertiary:

Symphony size required:

AROA™ Sales Representative:

CPT:

Legs/Arms/Trunk < 100 sq cm: ☐ 15271/15272

Legs/Arms/Trunk > 100 sq cm: ☐ 15273/15274

Feet/Hands/Head < 100 sq cm: ☐ 15275/15276

Feet/Hands/Head > 100 sq cm: ☐ 15277/15278

Authorization and Consent

*Signed Business Associates Agreement (BAA) on file with Aroa Biosurgery Inc. ☐ Yes ☐ No

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. 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: / /

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.