Smith+Nephew Reimbursement Hotline Services
PICO◇ sNPWT Insurance Verification Request (IVR)
Form Phone: 866-988-3491 **Fax:** 866-304-6692

Smith+Nephew

1.Type of Insurance Verification Requested

☐ New Wound ☐ Additional Applications ☐ Re-Verification ☐ New Insurance ☐ Check Out-Of-Pocket Maximum

If a prior authorization is required, I authorize Smith and Nephew to initiate the authorization. **Please select one:** ☐ **Yes** ☐ **No**
***If yes**, please attach all clinical notes related to the wound treatment episode.*

2. Patient Information: *Please list the patient's name on this form when attaching a face sheet*

First Name:	Last Name:			M.I.:
Address:	Apt./Suite#:	City:	State:	Zip:
Date of Birth:	Gender: ☐ Female ☐ Male	Phone #:		

3. Insurance Information: *Please attach a copy (Front & back) of patient's insurance card(s)*

Cardholder Name/Relationship:		Date of Birth:
Primary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:
Secondary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:
Tertiary Payer:		Plan Type:
Policy #:	Group #:	Card Phone #:

4. Healthcare Provider (HCP) & Facility/Agency Information: *Please note, we do not verify inpatient benefits*

HCP First Name:	HCP Last Name:	M.I.:
HCP NPI:	HCP Tax ID#:	HCP PTAN#:
Specialty: ☐MD ☐DO ☐DPM ☐PA ☐NP/FNP ☐ Other: _____		HCP Payer ID/Medicaid PIN:
Contact Name:	Phone #:	HCP Network Status: ☐In ☐Out
Facility/Agency Name:		Facility/Agency Network Status: ☐In ☐Out
Facility/Agency Address:	Facility/Agency NPI:	Phone #:
City, State, Zip:	Facility/Agency Tax ID:	Fax #:
Managing Facility Address (if different):		MAC/Fiscal Intermediary:

Place of Service: ☐Physician Office (POS11) ☐Hospital Outpatient Department (POS19/22) ☐Telehealth (POS11)
☐Home Visit (POS12) ☐Home Health Agency (POS12) ☐Other POS: _____

Is the patient currently receiving home health agency care?: ☐*Yes or* ☐*No* ***If yes,** will the agency supply the product?* ☐*Yes or* ☐ *No*

Is the patient currently in a SNF?: ☐Yes or ☐No ***If yes,*** ☐Under 100 days (Skilled-POS31) *or* ☐Over 100 Days (Unskilled-POS32)

SNF Name:	Contact Name:	SNF Phone#:

5. Treatment & Wound Information: *Please note, wound diagnoses codes are required and should be listed to include the specific anatomical site, type of wound, and etiology whenever possible. Missing information will result in processing delays.**

ICD-10-CM Diagnosis Codes*:

Primary: _____; _____

Secondary: _____; _____

Other: _____; _____

Select One: ☐ PICO 7 ☐ PICO 7Y ☐ PICO 14

Wound Information:

☐Total Wound(s) surface area ≤ to 50 square centimeters (CPT 97607)

☐Total Wound(s) surface area ≥ than 50 square centimeters (CPT 97608)

☐Application Date: _____ Number of Anticipated Applications: _____

6. Healthcare Provider Signature: *Please include all required information and sign below*

By signing below, I certify that I have obtained a valid authorization from the patient listed on this form permitting me to release the patient's protected health information (PHI) to the Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to PICO◇ products on behalf of the patient. I further understand that completing this form does not guarantee that insurance coverage or reimbursement will be provided to the patient. I certify that the information provided on this form is current, complete, and accurate to the best of my knowledge. **For typed or stamped signatures below:** I agree that this typed or stamped signature has the same validity and meaning as my handwritten signature.

HCP Signature: _____ **Date:** _____

Disclaimer: The Smith+Nephew Reimbursement Hotline is an information service only. Benefits information is provided by the insurer or third-party payer. Results of this research are not a guarantee of coverage or reimbursement now or in the future, and Smith & Nephew disclaims liability for payment of any claims, benefits or costs.

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Instructions on Completing the Insurance Verification Request Form (IVR): *Please see below*

Step 1: The IVR form must be completed by the provider/provider staff and submitted by the account/office. Please complete and sign the IVR form in its entirety and refer to the required information below to minimize processing delays.
Step 2: Fax the completed IVR to the fax number listed above.
Step 3: There is a 48-hour turnaround time for complete forms received. Please ensure all applicable fields are completed prior to faxing.

1. Type of Insurance Verification Requested: *Check the box for one of the following*

New Wound: When a new episode of treatment begins for a new wound.
Additional Applications: When more than the originally requested quantity is needed or requires additional authorization.
Re-Verification: When a re-verification is needed during the current episode of treatment or a new benefit year with the same insurance begins.
New Insurance: When a new insurance has been identified for an existing S+N patient undergoing treatment and requires investigation. **Check Out-Of-Pocket Maximum:** When an out-of-pocket maximum check is needed for an existing S+N patient undergoing treatment.
If you would like assistance with initiating and tracking prior authorizations, please check the Prior Authorization "Yes" box and provide all pertinent clinical documentation (Ex: wound measurements LxWxD, etiology, anatomical location, recent A1c if required, etc).
Note: Instructions will be reported on the results form, please review instructions carefully.

2. Patient Information: *Please list the patients name on the form when attaching a face sheet*

Patient demographics are **required** for the completion of the patient Insurance Verification Request.
Option 1: Complete all patient information in section 2 in its entirety.
Option 2: Indicate the patient name on the IVR form and include a copy of the patient face sheet that provides the patient demographics.

3. Insurance Information: *Please attach a copy (front & back) of patient's insurance card(s)*

Patient insurance information is **required** to research benefits. **Please indicate all active policy information**. Please provide a copy of the patient's insurance card(s) when possible (front *and* back). Note: For Workman's Compensation please include date of injury and claim adjuster contact information. For Veterans Administration insurance please include the local Veterans Affairs facility affiliation.
Please note - **Global Surgery Period: The PICO product (and its application) currently does not have a global period associated. The global surgery period includes all necessary services normally furnished by the performing surgeon and/or group practice before, during, and after a surgical procedure. Global surgery period guidelines may differ by payer.**

4. Healthcare Provider (HCP) & Facility Information: *Please note, we do not verify inpatient benefits*

Healthcare Provider Information is required for completion of the patient Insurance Verification Request. Please list all pertinent credential information as listed on the form including National Provider Identification (NPI), Tax ID, Patient Transaction Access Number (PTAN), and Payer ID/ Medicare PIN which allows for communication with associated payers and appropriate collection of network status.
Facility/Agency Information is also required for completion of the patient Insurance Verification Request. Please list all pertinent credential information as listed on the form. Please include (when applicable) if a Managing Facility is used to bill claims and note Medicare Administrative Contractor/Fiscal Intermediary if different than that assigned to the listed physical address for treatment as this can affectthe benefit investigation.
Physician Office (POS11): Select when your place of service is physician owned.
Telehealth (POS11): Select only when the the intention is to provide Synchronous telemedicine services defined as a real-time interaction between a physician or other qualified healthcare professional (QHP) and a patient who is located at a distant site from the physician or other QHP.
Home Visit (POS12): Home and domiciliary visits are when a physician or qualified non-physician practitioner (NPPs) oversee or directly provide visits in a beneficiary's home. This is to improve medical care in a home environment. A provider must be present and provide face to face services. This is not to be confused with home healthcare incident to services.
Home Health Agency Care (POS12): Select when services are provide at a location, other than a hospital or other facility, where the patient receives care in a private residence by a
Hospital Outpatient Department (POS19/22): Select when your place of service is hospital owned under 19-Off Campus or 22-On Campus.
Skilled Nursing Facility (POS31/32): Select when the patient resides in a SNF/Nursing Facility and confirm length of stay. Please also include SNF name and contact information as necessary.
Other POS: If selected, please clearly state the place of service on the line provided. For Example: CAH or Critical Access Hospital

5. Treatment & Wound Information: *Please include all pertinent information associated to the patient's treatment and condition*

Treatment & Wound Information is required. Please be sure to select the preferred treatment with wound information, and ICD-10-CM (diagnosis) that is pertinent to the condition for which this treatment is prescribed. A wound diagnosis code should be listed as primary for NPWT and include the specific anatomical site and type of wound requiring treatment for consideration of coverage and payment. Please utilize correct coding practices for ICD-10-CM and code to the highest level of specificity whenever possible. Please review for etiology (disease condition) and anatomical location - Ex: Code diabetes or venous insufficiency and ulcer location separately. Note: Use of unspecified and/or not otherwise specified codes may result in delayed benefit investigation results. Please consider review of specific payer policies for additional information whenever possible.

6. Healthcare Provider Signature:

Healthcare Provider Signature is required. This serves as certification that the provider has obtained valid authorization from the patient listed on this form permitting release of the patient's protected health information (PHI) to Smith+Nephew Reimbursement Hotline Services, Smith & Nephew, Inc., its contractors, and the patient's health insurance company as necessary to research insurance coverage and payment information to determine benefits related to PICO◇ products on behalf of the patient. This further certifies that the HCP understands that by completing this form, it does not guarantee that insurance coverage or reimbursement will be provided.

Questions? The Smith+Nephew Reimbursement Hotline is available Monday-Friday between the hours of 8:00 am and 7:00 pm ET at 1-866-988-3491.

Distributed by:
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