



celularity

Patient Intake Form

Biovance®

Interfyl®

UltraMIST®

COMPLETED FORMS MUST BE FAXED TO THE CELULARITY REIMBURSEMENT HOTLINE AT 877-908-2351.
FOR ASSISTANCE, PLEASE CALL 1-844-963-2273, PROMPT 5

Account Executive contact information: Name _____

PATIENT INFORMATION: *Please submit copies of insurance cards (front & back) and patient demographics sheet

Patient Name:		DOB:	
Address:		City:	
State:	Zip code:		
Primary Ins:	Ins ID#:	Group #:	Ins. Phone:
Secondary Ins:	Ins ID#:	Group #:	Ins. Phone:
Is patient currently in a surgical global period?		Yes	No
If yes, what is the CPT surgery code?		Surgery Date?	
Is patient currently residing in a nursing home or skilled nursing facility?		Yes	No

PROVIDER INFORMATION:

Place of Service:	Physician Office (11)	Ambulatory Surgical Center (24)
	HOPD (22) or Off-Campus (19)	Other: Inpatient/SNF/Rural/Critical Access or Other
Rendering Physician Name:		
NPI:	TIN:	Medicare PTAN:
Address:		Provider phone:
City/State:		Provider fax:
Primary Contact Person:		Contact Phone:
Contact Email Address:		Contact Fax:

FACILITY INFORMATION:

Facility Name:	Facility Phone:	Facility Fax:
Facility Address:		
Facility TIN:	Facility NPI:	
Medicare PTAN (Group):		
Primary Contact Person:	Contact Phone:	
Contact Email Address:	Contact Fax:	

PROCEDURE INFORMATION * Please attach all supporting clinical documentation such as treatment plan, progress notes, and LOMN.

Procedure Date:		
Diagnosis ICD-10 codes:	CPT/HCPCS Code(s):	
Wound Size:	Wound location:	
Additional Patient Notes:		
For Biovance and Interfyl only:	Number of Grafts:	Size of Initial Graft: (in sqcm or mg)
Physician Signature:	Date:	

The signature above certifies that the physician has the necessary patient authorization to release the medical and/or patient information to Celularity, its contractors and the patient's health insurance company as necessary to research insurance coverage and determine benefits related to Celularity products.

COVERAGE, REIMBURSEMENT AND/OR BENEFIT VERIFICATION FOR ANY PRODUCT OR PROCEDURE CANNOT BE GUARANTEED, AND THE CELULARITY REIMBURSEMENT HOTLINE AND CELULARITY DISCLAIM LIABILITY FOR PAYMENT OR NONPAYMENT OF ANY CLAIMS, BENEFITS OR COSTS. THIRD-PARTY PAYMENT FOR MEDICAL PRODUCTS AND SERVICES IS AFFECTED BY NUMEROUS FACTORS. IT IS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES AND MODIFIERS FOR SERVICES RENDERED.