Metairie Medical
Durable Medical Equipment

INSURANCE VERIFICATION REQUEST

Fax: (504) 313-1540
Email: george.bolaris@metairiemedical.com
Phone: (407) 484-0363

Distributor Name:_____ Distributor Email:_____

PLEASE PROVIDE ANY ADDITIONAL E-MAIL ADDRESS FOR BIOLAB HOLDINGS TO SEND RESULTS TO:

E-mail:_____ E-mail:_____
E-mail:_____ E-mail:_____
E-mail:_____ E-mail:_____

PATIENT INFORMATION:

LAST NAME:_____
FIRST NAME:_____
DOB:_____
PATIENT'S ADDRESS:_____CITY: _____
STATE:_____ ZIP CODE:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____
PRIMARY POLICY #:_____
SECONDARY INSURANCE:_____
SECONDARY POLICY #:_____

REQUESTING PROVIDER INFORMATION:

PROVIDER NAME:_____
PROVIDER NPI#:_____
TAX ID#:_____
PTAN#:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
OFFICE CONTACT NAME:_____
PHONE:_____EXT:_____
FAX:_____

PLACE OF SERVICE INFORMATION:

FACILITY NAME:_____
FACILITY NPI#:_____
TAX ID#:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____

SERVICE TYPE:

☐ OUTPT ☐ OFFICE ☐ SURGERY CTR ☐ HOSPICE
☐ OTHER:_____

SERVICES:

DOS:_____

PRODUCT (CHECK ONE AND ADD UNITS):

Membrane Wrap™ (Q4205):_____ units/cm² X _____ applications = _____ total anticipated units
Membrane Wrap - Lite™ (Q4373):_____ units/cm² X _____ applications = _____ total anticipated units
Membrane Wrap - Hydro™ (Q4290):_____ units/cm2 X _____ applications = _____ total anticipated units
Tri-Membrane Wrap™ (Q4344):_____ units/cm2 X _____ applications = _____ total anticipated units
Microlyte® SAM™ (A2005):_____ units/cm² X _____ applications = _____ total anticipated units
Microlyte® PainGuard™ (A2040): _____ units/cm2 X _____ _ applications = _____ total anticipated units
Apis® (A2010): _____ units/cm2 X _____ _ applications = _____ total anticipated units

ICD-10 DIAGNOSIS CODE(S):_____ _____ _____ _____ _____ _____ _____ _____ _____ _____
CPT APPLICATION CODE(S):_____ _____ _____ _____ _____ _____ _____ _____

STOP

PROVIDER SIGNATURE:_____ DATE:_____

ALL SECTIONS OF THIS FORM MUST BE COMPLETED. ANY MISSING INFORMATION COULD DELAY THE PROCESSING TIME OF THE REQUEST. IF YOU NEED ASSISTANCE FILLING OUT THIS FORM, PLEASE CONTACT THE CLIENT SERVICES TEAM.

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's evidence of coverage.