Prior Authorization Checklist - For Internal Use Only

Do Not Submit This Checklist or Supporting Documentation to ACell or ACell Representatives

ACell does not provide prior authorization services.

This checklist is for office use only. Some insurers require use of their own form. Please follow directions provided by the patient's insurer. Submit all relevant clinical data to support requested service, including, but not limited to, progress notes, treatments rendered, tests, lab results, and diagnostic reports.

You may contact the ACell Reimbursement Support Center to check the patient's health plan coverage policy prior to submitting a prior authorization request to the payer.

(For Office Use Only)

If Prior Authorization is done by telephone:
Name of prior authorizing agent: ______________________
Prior authorization number: ______________________

If Prior Authorization is done by fax:
Fax number: ______________________
Confirmation of receipt: ______________________

Patient and Insurance Information

Primary Insurer: ______________________ Patient ID/Policy Number: ______________________
Name of Insured: ______________________
Secondary Insurer: ______________________ Patient ID/Policy Number: ______________________
Name of Insured: ______________________ Patient Date of Birth: ______________________
Treatment related to work injury or an accident? ❑ Yes ❑ No

Type of Request

❑ Routine
❑ Expedited/Urgent. (Request must include a physician's order stating that waiting for a decision under a standard time frame could endanger the member's life, health, or ability to regain maximum functionality or would cause serious pain.)

❑ Inpatient ❑ Outpatient ❑ Office

Servicing Provider and Facility Information

Servicing Provider: ______________________ TIN/NPI: ______________________
Address: ______________________ Fax: ______________________
Date of Service: ______________________ ❑ In network ❑ Out of network
Servicing Facility: ______________________ TIN/NPI: ______________________
Address: ______________________ ❑ In network ❑ Out of network

Clinical Information (Documented in the patient record)

ICD-10-CM Diagnoses: ______________________
ICD-10-PCS Procedure Codes (Inpatient): ______________________
Required CPT Code(s): ______________________
Required HCPCS Code(s): ______________________
Miscellaneous and/or Unlisted Codes Description Required: ______________________
Wound Type, (DFU, VSU, Other), Location(s) and Size(s): ______________________
Date of Onset: ______________________
Previous Treatment(s), Service Description/CPT/HCPCS Codes: ______________________

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ACell Resources

Please consult the ACell Reimbursement Guides for information about product and procedure coding that may apply, in addition to relevant code books, at **www.acell.com/reimbursement**

For additional assistance, please contact the ACell Reimbursement Support Center: **800-826-2926 Option 7** | **reimbursement@acell.com**

Disclaimer: Documentation must reflect services performed. This information is shared for educational purposes only. While ACell believes this information to be correct, information is subject to change without notice.

The decision of how to complete a reimbursement claim form, including codes and amounts to bill, is exclusively the responsibility of the QHPs and other providers. Coding requirements are subject to change at any time; please check with your local payer regularly for updates.

Confidentiality Notice: The documents in this correspondence may contain confidential health information that is privileged and subject to state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA).

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