ONCE FORM IS COMPLETE, FORWARD TO THE PINNACLE HEALTH GROUP
FAX: 877-499-2986 / EMAIL: BV@THEPINNACLEHEALTHGROUP.COM
QUESTIONS: FOR ASSISTANCE CALL 866-369-9290

REASON FOR REQUEST (check all that apply): ☐ PATIENT BENEFIT VERIFICATION ☐ PRIOR AUTHORIZATION REQUEST

PROVIDER INFORMATION:

Procedure Date:			
Place of Service: ☐ **Physician Office** ☐ **Ambulatory Surgical Center** ☐ **Hospital Inpatient** ☐ **Hospital Outpatient** ☐ **Other:**			
Rendering Physician Name:			
NPI:	**TIN:**		**Medicare PTAN:**
Address:			**Provider Phone:**
City:	**State:**	**Zip Code:**	**Provider Fax:**
Contact Person:			**Contact Phone:**
Contact Email Address:			**Contact Fax:**

FACILITY INFORMATION:

Facility Name:	**Facility Phone:**	**Facility Fax:**
Facility Address:		
Facility TIN:	**Facility NPI:**	

PATIENT INFORMATION:

Patient Name:		
Address:		**City:**
State:	**Zip Code:**	**Gender:**
DOB:	**Home Phone:**	**Cell Phone:**
Primary Ins:	**Ins ID#:**	**Group#:**
Ins. Phone:	**Subscriber Name:**	**Subscriber DOB:**
Secondary Ins:	**Ins ID#:**	**Group#:**
Ins. Phone:	**Subscriber Name:**	**Subscriber DOB:**

PROCEDURE INFORMATION:

Diagnosis:	**ICD-10:**	**CPT/HCPCS Code:**
Product to be utilized: ☐ **Cytal** ☐**MicroMatrix** ☐ **Gentrix Surgical** ☐ **Gentrix Incisional** ☐ **Xpansion** ☐ **ABRA Abdominal** ☐ **ABRA Surgical**		
Number of Grafts:	**Size of Graft (sq cm):**	**Mg used (MicroMatrix Only):** **Sq cm used (Cytal and Gentrix):**

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

ACell Sales Rep Name:

THE PINNACLE HEALTH GROUP CANNOT GUARANTEE COVERAGE OR REIMBURSEMENT FOR ANY PRODUCT OR PROCEDURE, NOR IS BENEFIT VERIFICATION A GUARANTEE OF COVERAGE FOR SERVICES RENDERED. THIRD-PARTY PAYMENT FOR MEDICAL PRODUCTS AND SERVICES IS AFFECTED BY NUMEROUS FACTORS. IT IS ALWAYS THE PROVIDER'S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES AND MODIFIERS FOR SERVICES RENDERED.