Smith & Nephew PICO® NPWT Reimbursement Helpline
Insurance Verification Request Form
Phone: 888-705-0061 • Fax: 800-472-3848
Hours of operation: Monday through Friday 9:00 am to 5:30 pm (ET)

Please complete form or attach face sheet with same details.

Date Device Needed _____ (Note: If this date is not specified, results will typically be provided within 2 business days)

Patient and payer information

Patient name:	Date of birth:	☐ Female ☐ Male	
Address:	City:	State:	Zip code:
Phone:	Social security number:		

Is the patient currently in a skilled nursing facility? ☐ Yes ☐ No
☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid
☐ Other: describe_____

Is the patient currently receiving home health agency care? ☐ Yes ☐ No
☐ Medicare Part A ☐ Medicare Part B ☐ Medicaid
☐ Other: describe_____

Will the patient be in a global surgery period when they receive the disposable PICO NPWT System? ☐ Yes ☐ No

Primary insurance:	**Secondary insurance (no Supplemental):**
Payer phone number:	**Payer phone number:**
Policy number:	Policy number:
Subscriber name:	Subscriber name:

Qualified Healthcare Professional (QHP) and facility information

QHP name:	Specialty:		
QHP NPI or Tax ID:	Is QHP in Network with Payer?: ☐ Yes ☐ No ☐ Unknown		
QHP address:	City:	State:	Zip code:
QHP contact:	Phone number:	Fax number:	
Facility/agency name:			
Facility/agency NPI or Tax ID:	Is Facility/Agency in Network with Payer?: ☐ Yes ☐ No ☐ Unknown		
Facility/agency address:	City:	State:	Zip code:
Facility/agency contact:	Phone number:	Fax number:	

Treatment setting (where PICO will be applied):

☐ QHP Office
☐ Skilled Nursing Facility (SNF)
☐ Home Health Agency
☐ Hospital Based Outpatient Wound Department (HOPD)
☐ Ambulatory Surgery Center (ASC)
☐ Other (specify Facility type):_____

Application of disposable PICO Negative Pressure Wound Therapy System research information (Note: 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.)

ICD-10-CM Diagnosis Codes Only (see note above)	Primary:	Secondary:
	Additional diagnosis codes:	
Wound size:	☐ Total wound(s) surface area less than or equal to 50 square centimeters ☐ Total wound(s) surface area greater than 50 square centimeters	

Smith & Nephew PICO° NPWT Reimbursement Helpline
Insurance Verification Request Form
Phone: 888-705-0061 • Fax: 800-472-3848
Hours of operation: Monday through Friday 8:00 am to 5:00 pm (ET)

Please complete form or attach face sheet with same details

Authorization for research

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 to the Smith & Nephew PICO Reimbursement Helpline, Smith & Nephew, Inc., and/or to its contractors as necessary to obtain insurance coverage and payment information regarding the PICO Single Use NPWT System.

Signature of Authorized Personnel:_____ Date:_____

(Patient signature only required if QHP did not sign above):
By signing this authorization, I, the patient, authorize my healthcare provider to use and/or disclose protected health information (PHI) related to the PICO Single Use NPWT System from my health records and insurance information to the Smith & Nephew PICO Reimbursement Helpline, Smith & Nephew, Inc., and/or to its contractors as necessary to obtain insurance coverage and payment information regarding PICO. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and will no longer be protected by federal privacy regulations. In carrying out these activities, the Smith & Nephew PICO Reimbursement Helpline, Smith & Nephew, Inc., and/ or to its contractors may relay information to health insurer(s), receive information from health insurer(s), and communicate such information to my healthcare provider. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand that my refusal to sign does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits. I understand that if I choose to revoke this authorization, I must do so in writing to my healthcare provider.

Signature of Patient or Guardian :_____ Date:_____

Please fax this form along with a copy of the front and back of the patient's insurance card to: 800-472-3848

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