Integra®
Reimbursement Hotline Services

INTEGRA®
LIMIT UNCERTAINTY

Reimbursement Information Request (RIR) Form

New Wound Additional Applications Re-Verification

Patient Information

Patient Name: _____ Date of Birth: _____

Gender: Male Female Phone Number: _____ Social Security #: _____

Address: _____ City, State, Zip: _____

Is this patient residing in a Skilled Nursing Facility or Nursing Home? Yes No
If yes, are they in a skilled bed or center (Under 100 days)? Yes No
If no, are they in a long-term/custodial bed or center (Over 100 days)? Yes No

Treatment Information

Date of 1st Application: _____ Anticipated # of Applications: _____

Product to be applied: Omnigraft® Dermal Regeneration Matrix: Q4105 PriMatrix® Dermal Repair Scaffold: Q4110
PriMatrix® AG Antimicrobial Dermal Repair Scaffold: Q4110 AmnioExcel® Amniotic Allograft Membrane: Q4137
Other Product _____

Diagnosis (Please follow the 5-7 digit format within the ICD-10-CM coding system)

Primary Diagnosis Code: _____ Secondary Diagnosis Codes: _____ Other Codes: _____

Wound Status Clean non-infected wound Tried / failed conservative treatment measures

Place of Service (Check one)

Physician Office (11) Free-Standing ASC (24) On Campus-Outpatient Hospital (22) Off Campus-Outpatient Hospital (19)
Hospital-Based ASC (24) Critical Access Hospital (22) Other: _____

If Prior authorization is required or Predetermination is recommended, please check here if you would like assistance from the Hotline.

Patient Insurance Information - Please attach any additional information

Primary Payer Name: _____ Secondary Payer Name: _____
Policy #: _____ Policy #: _____
Group #: _____ Group #: _____
Payer Phone #: _____ Payer Phone #: _____
Subscriber Name/Relation: _____ Subscriber Name/Relation: _____
Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Physician Information

Participating Status (check one): In-Network Out-of-Network
Physician Name: _____ Physician Specialty: _____
Practice Name: _____ Address: _____
City, State, Zip: _____ Phone #: _____ Fax #: _____
Contact Name: _____ Physician's Tax ID #: _____ Physician's NPI #: _____

Facility Information

Participating Status (check one): In-Network Out-of-Network

Facility Name: _____ Fiscal Intermediary: _____
Address: _____
City, State, Zip: _____ Phone #: _____ Fax #: _____
Contact Name: _____ Facility Tax ID #: _____ Facility NPI #: _____

Do you have a Business Associate Agreement (BAA) signed with Integra? Yes No
To complete a BAA, if not already on file, please contact the Hotline at 1-877-444-1122, option 3

Physician Signature: _____ Date: _____

Please Fax Completed Form to: 1-888-807-0571

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Reimbursement Information Requests must be completed by the provider staff and submitted by the account

- Step 1: Complete and sign the RIR form. Please refer to the required information below. Please be sure to complete the information to minimize delays.
- Step 2: Fax the completed RIR form to the Integra Reimbursement Hotline at 1-888-807-0571 or submit via email to smartreimbursement@integralife.com. Please be sure to use the correct fax number on the request form.
- Step 3: There is a 48 hour turnaround for completed forms received. Please ensure all applicable fields are completed prior to faxing.

Patient Information

- Option 1: Complete all patient information (Name, DOB, Insurance Name, Policy ID number(s))
- Option 2: Indicate the patient name on the RIR and include a copy of the patient face sheet for patient demographics

Required Treatment Information

- Place of Service (select one, benefits may differ for each) – Physician Office, Free Standing ASC, Hospital Outpatient, On Campus-Outpatient Hospital, Off Campus-Outpatient Hospital, Hospital-based ASC, Critical Access hospital or other (indicate what if other)
- Diagnosis Codes – List all applicable codes in the 5-7 digit format. Missing digits will result in delays
- Is wound clear of infection?
- Has wound failed to respond to documented conservative measures?

Prior Authorization Assistance

- Check this box if you would like the Integra Reimbursement Hotline's assistance in tracking prior authorizations with the insurance carrier if required
- Instructions will be reported, please be sure to review return instructions carefully

Insurance Information

- Patient insurance information is required to research benefits. Please indicate all active policy information.
- Please provide a copy of the patient's insurance card(s) when possible [front and back].

Required Physician and Facility Information

- Network status with the patient's group plan (if known)
- Fiscal intermediary - The Medicare Contractor used for payment determination (i.e., Novitas, NGS, WPS, etc.)
- Payer specific ID (if available) – Ex: PTAN
- Phone/Fax # – RIR results will be sent to the number(s) provided. Results can be faxed to multiple numbers/contacts
- Contact Name – Provide a valid contact person in the event additional information is needed
- Tax ID # and NPI # – Required for both provider and facility [used to check network status]
- Business Associate Agreement (BAA) – Check yes or no box.
  - If BAA is not on file, please contact the Integra Reimbursement Hotline or your Integra Representative for a copy.

Physician signature and Date

- The form must be signed and dated by the physician in order to be processed. Failure to sign will result in delays.

Questions? Need assistance? Call 1-877-444-1122, option 3

For more information or to place an order, please contact:

United States, Canada, Asia, Pacific, Latin America
USA 800-654-2873 ▪ 888-980-7742 fax
International +1 609-936-5400 ▪ +1 609-750-4259 fax
integralife.com/contact