Derma Sciences Reimbursement Support: Provider Intake Form

Please indicate products used: ☐ MEDIHONEY® ☐ Med E-Kast® ☐ TCC-EZ® ☐ AMNIOEXCEL®

TREATING FACILITY INFORMATION	
HOSPITAL/FACILITY NAME:	
Tax ID and NPI #:	
STREET ADDRESS:	
CITY, STATE, ZIP:	
PHONE:	
PHYSICIAN INFORMATION	
PRACTICE NAME:	
PHYSICIAN NAME(S):	
PHYSICIAN SPECIALTY:	
PHYSICIAN/PRACTICE TAX ID #:	
PHYSICIAN NPI #:	
OTHER PROVIDER # (i.e., BCBS)	
STREET ADDRESS:	
CITY, STATE, ZIP:	
PHONE:	
FAX:	
CONTACT INFORMATION	
OFFICE CONTACT:	
PHONE: (if different than above)	
EMAIL:	
BILLING CONTACT:	
PHONE:	

As part of the Derma Sciences Reimbursement Support program, I hereby authorize Argenta Advisors LLC, Argenta reSource Company, and their agents (Argenta) on behalf of Derma Sciences, Inc. to be my designated agent to provide any information on this form to an insurer for purposes of assisting and/or providing reimbursement or appeals support to my patient(s).

Provider Name (print) | x _____ Physician's Signature (or Authorized personnel) | Date

Please fax the completed form to 1-844-868-0930

July 2014