celularity®

Insurance Verification Request Form

Biovance® Ocular & Biovance® 3L Ocular

COMPLETED FORMS MUST BE FAXED TO THE CELULARITY REIMBURSEMENT HOTLINE AT 1-888-364-4436

FOR ASSISTANCE, PLEASE CALL 1-844-963-2273, PROMPT 5

Verséa Ophthalmics representative (name and email)

PATIENT INFORMATION: *Please submit copies of insurance cards (front & back) and patient demographics sheet		
Patient name:		**DOB:**
Address:		**City/State/Zip:**
Primary Insurance:	**Ins ID#:**	**Ins. Phone:**
Secondary Insurance:	**Ins ID#:**	**Ins. Phone:**
Workers Compensation or Other Insurance:		**Claim Adjuster's Name:**
Claim Number:	**Date of Claim:**	**Adjuster's Phone Number:**

PROVIDER INFORMATION:			
Site of Service:	**Physician Office (11)**	**HOPD (22)**	**Ambulatory Surgical Center (24)**
	Other (Please Write In):		
Rendering Physician Name:			
NPI:	**Tax ID:**	**Medicare PTAN:**	
Address:		**Provider Phone:**	
City / State:		**Provider Fax:**	
Primary Contact Person:		**Contact Phone:**	
Contact email address:		**Contact Fax:**	

PRACTICE/FACILITY INFORMATION:		
Name:		**Phone:**
Address:		**Fax:**
Practice/Facility NPI:	**Tax ID:**	**Group PTAN:**
Primary Contact Person:		**Contact Phone:**
Contact Email Address:		**Contact Fax:**

PROCEDURE INFORMATION: * Please attach all supporting clinical documentation such as treatment plan, progress notes, and	
Procedure Date:	
Diagnosis ICD-10 Codes:	
CPT Procedures Requested:	
Conditions Treated with Biovance 3L:	
Additional Patient Notes:	
Number of Grafts Intended:	
Physician Signature*:	**Date:**

The signature above certifies that the physician has the necessary patient authorization to release the medical and/or patient information to Celularity, its contractors and the patient's health insurance company as necessary to research insurance coverage and determine benefits related to Celularity products.

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