Integra®
Reimbursement Hotline Services

INTEGRA®
LIMIT UNCERTAINTY

Reimbursement Information Request (RIR) Form

☐ New Wound ☐ Additional Applications ☐ Re-Verification

Product to be applied: ☐ AmnioExcel® Amniotic Allograft Membrane or AmnioExcel® Plus+ Placental Allograft Membrane (Q4137) ☐ Omnigraft® Dermal Regeneration Matrix (Q4105) ☐ PriMatrix® or PriMatrix® AG Antimicrobial Dermal Repair Scaffold (Q4110) ☐ Other Product _____ (If selecting multiple products, please prioritize by placing a 1, 2, and/or 3 in the corresponding product(s) check box)

Patient Information

Patient Name: _____ Date of Birth: _____

Please attach face sheet for additional demographic information (Required)

Skilled Nursing Facility: Check all that apply:

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 yes, is the patient being transported by ambulance? ☐ Yes ☐ No

☐ Check here if you would like assistance from the Hotline if a Prior Authorization is required or Predetermination is recommended

Wound Information

Wound Type
- ☐ Diabetic Foot Ulcer
- ☐ Venous Leg Ulcer
- ☐ Chronic Ulcer
- ☐ Dehisced Surgical Wound
- ☐ Pressure Ulcer
- ☐ Burn

Other _____

ICD-10 Codes (REQUIRED)
Primary _____
Secondary _____
Other _____
No Diabetes ☐

Wound Description
Location of Ulcer _____
Duration of Ulcer _____
Size per sq cm area _____
Date of Procedure _____
Procedure Codes _____

Wound Status
- ☐ Clean non-infected
- ☐ Is bone/tendon exposed
- ☐ If Stage 1 ulcer, does it extend into fat layer

Provider Information

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 ☐ Other _____

Provider Name: _____ ☐ MD ☐ DO ☐ DPM ☐ CRNP/APRN ☐ PA
Provider ID #'s: NPI: _____ Tax ID: _____
Facility or Practice Name: _____
Facility NPI: _____ Facility Tax ID: _____
Facility or Practice Address: _____ City, State, Zip: _____
Contact Name: _____ Phone: _____ Fax: _____
Contact Email Address: _____

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 Reimbursement Hotline at 1-877-444-1122, option 3, option 1

Physician Signature: _____ Date: _____

Please Fax Completed Form to: 1-888-807-0571 or Email to: smartreimbursement@integralife.com

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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.

Product Information
- Select the name of the product you wish to use. If selecting multiple products, please prioritize by placing a 1, 2, and/or 3 in the corresponding product(s) check box.

Patient Information
- Indicate the patient's name and date of birth on the RIR and include a copy of the patient's face sheet for additional patient demographics (required).
- 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].

Skilled Nursing Facility (check all that apply)
- Indicate if patient is in a Skilled Nursing Facility, if they are in a skilled bed under 100 days, and/if they were transported by ambulance.

Prior Authorization/Predetermination Assistance
- Check this box if you would like the Integra Reimbursement Hotline's assistance with tracking Prior Authorizations and/or Predeterminations with the insurance carrier if required. Instructions will be provided, please be sure to review the return instructions carefully.

Wound Information
- Please indicate the type of wound: Diabetic Foot Ulcer, Venous Leg Ulcer, Chronic Ulcer, Dehisced Surgical Wound, Pressure Ulcer, Burn or indicate other type of wound.
- Diagnosis codes: List all applicable ICD-10 codes in the 5-7-digit format (missing digits will result in delays).
- Wound description: Provide location of ulcer, duration of ulcer, size per sq. cm area, date of procedure and applicable procedure codes.
- Wound Status: Is wound clear of infection? Is there exposed bone/tendon? If Stage 1 ulcer, does it extend into fat layer?

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)

Required Physician and Facility Information
- Provider/Facility Name and full address, as well Tax ID # and NPI # – Required for both provider and facility [used to check network status
- 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
- Contact email address: Provide a valid email address for the contact person if additional information is needed

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, option 1

Disclaimer: Integra has used reasonable efforts to provide accurate coding advice, but this advice should not be construed as providing clinical advice, dictating reimbursement policy or substituting for the judgment of a practitioner. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered. Provider is responsible for verifying coverage with the patient's insurance carrier. Integra LifeSciences Corporation assumes no responsibility for the timeliness, accuracy and completeness of the information contained herein. Since reimbursement laws, regulations and payor policies change frequently, it is recommended that providers consult with their payors, coding specialists and/or legal counsel regarding coverage, coding and payment issues.

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