Omeza Reimbursement Support

Fax completed enrollment form to 844-375-4063

OMEZA

Patient Information:

First Name:	Last Name:	SSN:	DOB:
Home Address:	City:	State:	Zip:
Home Phone:	Mobile Phone:	Gender ☐ Female ☐ Male	

Insurance Primary:

Plan Name:	Plan Phone #
Member ID:	Group #

Insurance Secondary:

Plan Name:	Phone #
Member ID:	Group #

Physician Information:

Full Name:	NPI	Tax Id	License	PTAN
Address:	City:	State: Zip:	Phone	Fax:

Setting Of Care:

☐ Office ☐ Home ☐ Assisted Living ☐ Group Home ☐ Mobile Unit

☐ Walk-In Retail Clinic ☐ Urgent Care ☐ Facility Outpatient ☐ Ambulatory Surg Ctn (ASC)

Diagnosis Code(s):

Primary ICD-10: _____

Secondary ICD-10 (if applicable): _____

CPT Code (if applicable):

☐ 11042 ☐ 97597 ☐ Other _____

Product Details:

Description:

Omeza Collagen Matrix, per 100 mg

HCPCS - A2014

1 vial of 1.6gm (16 units); single use application; no wastage , and short description

Quantity (# of vials):

_____

Physician Authorization:

By signing below, I certify that I have obtained all necessary federal and state authorizations and consents from my patient to allow me to release health information to Omeza Reimbursement Support and its contracted third parties to [1] supply information to the insurer of the above named patient [2] verify benefits and coordinate the dispense of Omeza products, [3] agree to the Business Associate Agreement as presented at baa.omezareimbursement.com

Healthcare professional signature: _____ Date: ____ ____ _____