

Patient Access Solutions Enrollment Form



Tapestry® Biointegrative Implant

(866) 946-0444

eFax: (877) 211-7271

Received: _____

email: reimbursement@zimmerbiomet.com

Provider of Care

Surgeon's Name:	
Practice Name:	
Point of Contact:	
Address:	
City, State, Zip:	
Tax ID #:	
NPI #:	
Email:	
Telephone Number:	
Fax Number:	
Referring Physician:	
Phone Number:	

Clinical Information

Primary Diagnosis:	
Diagnosis Code(s):	

Patient Information

Last Name:	
First Name:	
Address:	
City, State, Zip:	
SSN #:	____ - ____ - _____
Date of Birth:	
Email:	
Telephone Number:	
PHI Authorization:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Worker's Compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Facility Name _____

Address:	
Facility NPI #:	
Date of Service:	
Place of Service:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> ASC <input type="checkbox"/> Office

Tapestry Biointegrative Implant

Knee Hip Shoulder Subscapularis
 Anterior Tibialis Other _____

HCPCS Code(s): C1713, C1763

Procedure Location: Right Left Both
CPT® Code(s): _____

Insurance & Prior Authorization Information

Primary Carrier:	
Telephone Number:	
Subscriber:	
Group Number:	
Patient ID #:	
Provider ID #:	

Secondary Carrier:	
Telephone Number:	
Subscriber:	
Group Number:	
Patient ID #:	
Provider ID #:	

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Please check the level of support (Select only one option)

- Benefit Verification Only:** Confirm benefits only with no prior authorization support
- Benefit Verification and Prior Authorization:** Confirm benefits and assist with prior authorization support

By your signature below, you verify that the information being disclosed in this enrollment form is complete and accurate to the best of your knowledge. With the submission of this form, you are enrolling your patient into a patient support program that Zimmer Biomet makes available as a benefit to those patients. In providing this benefit to your patient, you agree that Zimmer Biomet is not your business associate under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). You are hereby notified and agree to notify patients that any personal data provided to Zimmer Biomet in connection with this form shall be processed in accordance with Zimmer Biomet’s Privacy Notice (<https://www.zimmerbiomet.com/en/corporate/privacy-notice.html>). For indications, contraindications, warnings, precautions, potential adverse effects and patient counseling information, see the instructions for use or contact your local representative; visit www.zimmerbiomet.com for additional product information. You understand that Zimmer Biomet reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue the program or any of its features.

HCP SIGNATURE

PRINTED NAME

DATE

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