Patient Access Solutions Enrollment Form



Customer Service: (855) 200-2760

Subchondroplasty® (SCP®) Procedure

Provider of Care Surgeon's Name: Practice Name: Point of Contact: Address: City, State, Zip: Tax ID #: Email: NPI #: Fax Number: Fax Number: Referring Physician: Phone Number: Phone Number: Primary Diagnosis: Diagnosis Code(s): Diagnosis Code(s): SCP Procedure Patient Information Last Name: Last Name: Stat Name: Address: First Name: Address: City, State, Zip: Date of Birth: Email: Telephone Number: PHI Authorization: Ves No Power's Compensation? Pacility Name Facility Name Facility NPI #: Facility Tax ID #: Date of Service: Inpatient Hospital Outpatient Hospital Outpatient Hospital Outpatient HCPCS Code: C1713 Procedure Location: Right Left Both CPT Code: 0707T	Received:	Fax requested information to: (855) 200-2761
Practice Name: Point of Contact: Address: City, State, Zip: Date of Birth: Email: NPI#: Tax ID#: Email: NPI#: Pellephone Number: Fax Number: Fax Number: Referring Physician: Phone Number: Phone Number: Clinical Information Primary Diagnosis: Diagnosis Code(s): Diagnosis Code(s): Bracklity Name Procedure Knee Hip Ankle & Foot Shoulder Procedure Location: Right Left Both	Provider of Care	Patient Information
Point of Contact: Address: Address: City, State, Zip: Date of Birth: Email: NPI #: Email: Telephone Number: Fax Number: Fax Number: Phone Number: Facility Name Facility NPI #: Facility NPI #: Date of Service: Place of Service: Place of Service: Place of Service: Procedure HCPCS Code: C1713 Procedure Location: Right Left Both	Surgeon's Name:	Last Name:
Address: City, State, Zip: Date of Birth: Email: Tax ID #: Email: NPI #: Email: Telephone Number: PHI Authorization:	Practice Name:	First Name:
City, State, Zip: Tax ID #: NPI #: Email: Telephone Number: Fax Number: Worker's Compensation?	Point of Contact:	Address:
Tax ID #: NPI #: Email: Telephone Number: PHI Authorization:	Address:	City, State, Zip:
Telephone Number: Email:	City, State, Zip:	Date of Birth:
PHI Authorization: Yes No	Tax ID #:	Email:
Telephone Number: Fax Number: Worker's Compensation? Yes No	NPI#:	Telephone Number:
Referring Physician: Phone Number: Address: Facility Name Facility NPI #: Facility Tax ID #: Date of Service: Inpatient HCPCS Code: C1713 Procedure Location: Right Left Both Both Both Right Left Both Both Right Left Right Right Left Right Right Left Right Right Left Right Righ	Email:	PHI Authorization: Yes No
Referring Physician: Phone Number: Clinical Information Primary Diagnosis: Diagnosis Code(s): Diagnosis Code(s): SCP Procedure Facility Name Facility NPI #: Facility Tax ID #: Date of Service: Inpatient Hospital Outpatient ASC Office Knee Hip Ankle & Foot Shoulder	Telephone Number:	
Address: Facility NPI #:	Fax Number:	Worker's Compensation? ☐ Yes ☐ No
Phone Number: Clinical Information Primary Diagnosis: Diagnosis Code(s): Diagnosis Code(s): Place of Service: Place of Service: BY Procedure Clinical Information Facility NPI #: Facility Tax ID #: Date of Service: Inpatient Hospital Outpatient ASC Office Coffice HCPCS Code: C1713 Procedure Location: Right Left Both	Referring Physician:	Facility Name
Primary Diagnosis: Date of Service: Date of Service: Inpatient Hospital Outpatient ASC Office Office HCPCS Code: C1713 Procedure Location: Right Left Both		Address:
Primary Diagnosis: Date of Service: Diagnosis Code(s): Place of Service: Place of Service: SCP Procedure Knee Hip Ankle & Foot Shoulder HCPCS Code: C1713		Facility NPI #:
Date of Service: Diagnosis Code(s):		Facility Tax ID #:
Place of Service: Hospital Outpatient ASC Office	Primary Diagnosis:	Date of Service:
HCPCS Code: C1713 Procedure Location: □ Right □ Left □ Both	Diagnosis Code(s):	Place of Service: Hospital Outpatient ASC
	□ SCP Procedure	□ Knee □ Hip □ Ankle & Foot □ Shoulder
	HCPCS Code: C1713	
Insurance & Prior Authorization Information	Insurance & Prior Authorization Information	
Primary Carrier: Secondary Carrier:	Primary Carrier:	Secondary Carrier:
Telephone Number: Telephone Number:	Telephone Number:	Telephone Number:
Subscriber: Subscriber:	Subscriber:	Subscriber:
Group Number: Group Number:	Group Number:	Group Number:
Patient ID #: Patient ID #:	· · · · · · · · · · · · · · · · · · ·	
Provider ID #: Provider ID #:		

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Patient Access Solutions Enrollment Form

Subchondroplasty® (SCP®) Procedure

Please check the level of suppo	ort (Select only one option	1)
☐ Benefit Verification Only: Co	nfirm benefits only with no	prior authorization support
☐ Benefit Verification and Prior	r Authorization: Confirm be	penefits and assist with prior authorization support
best of your knowledge. With the Zimmer Biomet makes available a Biomet is not your business associated and agree to not shall be processed in accordance privacy-notice.html). For indicated and agree the additional product information.	e submission of this form, y as a benefit to those patient ciate under the Health Insuratify patients that any personce with Zimmer Biomet's Pations, contraindications, instructions for use or control understand that Zimme	ng disclosed in this enrollment form is complete and accurate to the you are enrolling your patient into a patient support program that its. In providing this benefit to your patient, you agree that Zimme rance Portability and Accountability Act of 1996 ("HIPAA"). You are nall data provided to Zimmer Biomet in connection with this form Privacy Notice (https://www.zimmerbiomet.com/en/corporate warnings, precautions, potential adverse effects and patient stact your local representative; visit www. zimmerbiomet.com for a Biomet reserves the right at any time and for any reason, without the program or any of its features.
HCP SIGNATURE		
PRINTED NAME	DATE	_

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