Patient Access Solutions
Enrollment Form

Subchondroplasty® (SCP®) Procedure

ZIMMER BIOMET

Customer Service: (855) 200-2760
Fax requested information to: (855) 200-2761

Received: _____

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:	
Date of Birth:	
Email:	
Telephone Number:	
PHI Authorization:	☐ Yes ☐ No
Worker's Compensation?	☐ Yes ☐ No

Facility Name _____

Address:	
Facility NPI #:	
Facility Tax ID #:	
Date of Service:	
Place of Service:	☐ Inpatient ☐ Hospital Outpatient ☐ ASC ☐ Office

☐ SCP Procedure

☐ Knee ☐ Hip ☐ Ankle & Foot ☐ Shoulder

HCPCS Code: C1713

Procedure Location: ☐ Right ☐ Left ☐ Both

CPT Code: 0707T

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 #:	

Continued on reverse side.

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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