Access-To-Care
Enrollment Form

Subchondroplasty® (SCP®) Procedure

ZIMMER BIOMET
Your progress. Our promise.®

Received: _____

(866) 946-0444
eFax: (877) 211-7271
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:	☐ Yes ☐ No
Worker's Compensation?	☐ Yes ☐ No

Facility Name _____

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

☐ SCP® Procedure

Procedure Location: ☐ Right ☐ Left ☐ Both

☐ Knee | ☐ Hip | ☐ Ankle & Foot | ☐ Shoulder

CPT Code(s): _____

Insurance & Prior Authorization Information

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

Continued on reverse side.

Ver. 1/31/2020

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Please check the level of submission at which the case is being submitted to the ATC program:
□ Pre-Determination □ First Internal Appeal □ Second Internal Appeal □ External Review

Was prior authorization initiated?	□ Yes □ No	
If yes, was it denied?	□ Yes □ No	**Attach copy of any denial letters.**
Was denial appealed?	□ Yes □ No	
If yes, by whom?	□ Physician □ Member	**Attach copy of any appeal letters.**

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 you agree, that any business associate agreements previously executed between you and Zimmer Biomet, or any of its affiliates, relating to participation in this patient support program are terminated. You represent that you have obtained all necessary authorizations and consents from your patient to which this form relates to enroll that patient in the program and for the disclosure to Zimmer Biomet and its service providers the patient's information by you, the patient's health plan and any of the patient's other health care providers. You represent that those authorizations and consents authorize Zimmer Biomet and entities that Zimmer Biomet engages to support the program to receive, use and disclose information regarding the patient to implement, support and operate the program. 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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