

Access-To-Care Enrollment Form



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):	

Mobi-C® Procedure Level(s)

One-Level (22856) Two-Level (22858)

Other

Procedure: _____ CPT 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
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Facility Name _____

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

DeNovo® NT Graft | SCP® Procedure

Procedure Location: Right Left Both

Knee | Hip | Ankle & Foot | Shoulder

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 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attach copy of any denial letters.
<i>If yes, was it denied?</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was denial appealed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, by whom?</i>	<input type="checkbox"/> Physician <input type="checkbox"/> 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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