HEALTHCARE PROVIDER REQUEST FORM

Completed form may be faxed to: (877) 389-9848

General questions? Call (877) 331-5472 or email info@defencathsupport.com

CorMedix Therapeutics

DefenCath® Reimbursement Support Program

Hours of Operation

Monday - Friday: 8:00 AM - 8:00 PM ET

SERVICE(S) REQUESTED

Check all that apply: ☐ Benefit Verification ☐ Setting of Care Research ☐ Prior Authorization Assistance ☐ Claims Assistance

PATIENT INFORMATION

Patient Name	Date of Birth	Phone #	Gender: ☐ M ☐ F
Street Address	City	State	Zip Code
Primary Contact Name:	Relationship to Patient:		

PATIENT INSURANCE INFORMATION (Attach a copy of both the front and back of insurance cards, if available)

Primary Insurance	Insurer Phone #	Policy #	Group #
Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient:	
Rx BIN #	RX PCN #	RX Group #	
Secondary Insurance	Insurer Phone #	Policy #	Group #
Policy Holder's Name	Policy Holder's Date of Birth	Relationship to Patient:	
Rx BIN #	RX PCN #	RX Group #	

DIAGNOSIS and TREATMENT INFORMATION (Required)

Primary ICD 10: Secondary ICD 10:

CPT Procedures Requested: ☐ 90935 ☐ 90937 ☐ Other: HCPCS: ☐ J0911

PATIENT CLINICAL PRESENTATION

☐ Acute Renal Failure ☐ New to ESRD ☐ Established ESRD patient

Is the patient receiving dialysis via CVC? ◉ Yes ○ No ☐ if no:

Other:

AUTHORIZING HEALTHCARE PROVIDER (HCP) INFORMATION (Required)

HCP Name: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other:

Clinic/Facility Name: Specialty:

Address City State Zip Code

HCP Tax ID # HCP NPI #

FACILITY CONTACT

Primary Contact Person: Contact Phone:

Contact Fax: Contact Email:

TREATING SETTING of CARE

Setting of Care: ○ ESRD treatment facility ○ Hospital Inpatient ○ Hospital Outpatient ○ ASC ○ SNF ○ Other:

Treating Facility Name

Facility Billing Address City State Zip Code

Phone # Fax # Facility Billing NPI # Facility Tax ID #

AUTHORIZING HEALTHCARE PROVIDER CERTIFICATION AND CONSENT (Signature Required for any Service)

I certify to the best of my knowledge that the information above is accurate and complete. I have requested and received consent from the patient or the patient's guardian to enroll the patient in the designated CorMedix Reimbursement Support Program, and I agree to allow the CorMedix Reimbursement Support Program, or its authorized representative, to review the medical, financial and insurance records for this patient at any time for the purpose of verifying the patient's eligibility status. I also attest that I have secured the patient's or the patient's guardian's written permission, to the extent and in the form required by law, to disclose the information to the CorMedix Reimbursement Support Program's authorized representative. I further agree that the CorMedix Reimbursement Support Program may contact me and my office via telephone, fax and e-mail regarding this enrollment request and related follow-up, and that I can revoke my consent at any time.

X_____ Sign Here _____

Authorizing HCP's original signature (no stamped signatures) Date

Authorizing HCP:
I have read and agree to the terms detailed on this form.

This verification of benefits is not a guarantee of payment. This verification cannot take the place of written policy information from the payer. CorMedix Therapeutics may determine eligibility, monitor participation, and modify or discontinue any aspect of this Program at any time.

Confidentiality notice: The information contained in this facsimile may be confidential and legally protected. It is intended only for use of the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regard to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this document and delete from your system, if applicable.

To opt-out of receiving future faxes, please contact us at 877-331-5472 (phone) or 877-398-9848 (fax).

! Please include any additional information to support this request, including, but not limited to, insurance correspondence, lab results, office notes, letter of medical necessity, or alternate sites of care for evaluation of coverage.