



**SYNVISC Connection**  
Insurance Verification Request Form

Phone: (800) 982-8292

Fax: (800) 508-8083

[www.SynviscOne.com/reimbursement](http://www.SynviscOne.com/reimbursement)

Please complete all sections to prevent delays, and fax it to (800) 508-8083 for processing. Upon receipt, SYNVISIC Connection will contact the insurance company or companies listed below to determine if Synvisc-One® or SYNVISIC® is covered.

CONTACT NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

**PATIENT INFORMATION**

**SYNVISC Connection must have the patient's consent to conduct insurance research.** By providing consent, the patient authorizes us to contact the insurer to verify coverage for Synvisc-One and SYNVISIC and relay the patient's name, date of birth, social security number, diagnosis, insurance information, etc.

Do you have the patient's consent on file?  YES  NO

PATIENT NAME: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**DIAGNOSIS AND OTHER PERTINENT MEDICAL INFORMATION**

PRODUCT REQUESTED:  Synvisc-One  SYNVISIC Anticipated Date of Service: \_\_\_\_\_

Diagnosis  715.16 (Osteoarthritis, localized, primary)  715.36 (Osteoarthritis, localized, not specified primary/ secondary)  
 715.26 (Osteoarthritis, localized, secondary)  715.96 (Osteoarthritis, unspecified general or localized)  
 Other (please specify): \_\_\_\_\_

Specify which knee  Right  Left  Bilateral Is this a retreatment?  Yes (date of last treatment) \_\_\_\_\_  No

Setting of Care  Physician's Office  Hospital Outpatient  Other (please specify): \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY INSURANCE:  
(Insurer Name and State) \_\_\_\_\_

Participating Provider:  YES  NO Payer Provider Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_

SECONDARY INSURANCE:  
(Insurer Name and State) \_\_\_\_\_

Participating Provider:  YES  NO Payer Provider Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group/Plan Number: \_\_\_\_\_

If you have tertiary insurance, please fill out an additional Insurance Verification Request Form.

**SPECIALTY PHARMACY (SPP)**

Do you want SYNVISIC Connection to research SPP options and provide you with the necessary SPP order forms, if available?

YES (default)  NO, office will buy and bill for Synvisc-One or SYNVISIC

**PHYSICIAN INFORMATION**

PRESCRIBING  
PHYSICIAN NAME: \_\_\_\_\_

NPI Number: \_\_\_\_\_ Tax ID Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Provider Specialty: \_\_\_\_\_ DEA Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_