Billing Tracking Form

Service Location ____________________

Facility	
Provider	
Patient Name	
Surgery Date	
Product Name	

	Yes	No
1. Was all graft material used?	◯	◯
a. If not, how much was discarded in cm? ____________		
2. Is the patient a diabetic?	◯	◯

3. Wound size in cm:____

4. Total graft size used in cm per wound:____________________________

5. Location of the wound(s): ______________________________________

6. Type of wound(s): ____

7. Diagnosis code(s):____

8. Additional CPT code(s): 15271 15272 15273 15274 15275 15276 15277 15278

Provider Signature	
Date	

DISCLAIMER: The Client is solely responsible for ensuring proper and timely documentation of all services to be billed by All in Won on its behalf, and to ensure retention and integrity of the medical records necessary for All in Won' accurate code assignment and claim submission. Client certifies that the information submitted to All in Won by the Client and its providers to prepare, file and submit claims for payment on Client's behalf is true, accurate and complete. Client is solely responsible for implementing compliance safeguards necessary to record and document services rendered to support each claim (including but not limited to time spent,provider identity, diagnoses and procedures) based on the medical record. The Client and its providers have familiarized themselves with current reimbursement principles set out in applicable laws, regulations,and payer policies.

Please return to your RxWound rep and krystal@rxwound.com