Barricaid® Provider Request Form

Please complete form and submit via confidential fax (844) 288-2660 or email reimbursement@barricaid.com. Please include supporting documentation.

INTRINSIC THERAPEUTICS

Patient Information | *Please attach a legible copy of both sides of the patient's insurance card (front and back) (if not provided, please complete below)*

Patient Name: _____

Patient Address: _____

City/State: _____

Date of Birth: _____

Patient Mobile #: _____

Health Plan Name: _____

Policy/Member ID #: _____

Group #: _____

Patient Email: _____

Surgeon Information

Surgeon Name: _____

Surgeon TIN: _____

Surgeon NPI#: _____

Office Contact Information

Office Contact Name: _____

Office Contact Phone #: _____

Office Contact Title: _____

Office Contact Email: _____

Coding Information

CPT Codes:
(Select appropriate laminotomy code)

- ☑ C9757
- ☑ 22899
- ☐ 63030
- ☐ 63042

Patient dx: *(See coding suggestions (HE005) for reference)*

Primary (disc herniation)

- ☐ M51.26
- ☐ M51.27
- ☐ M51.36
- ☐ M51.37
- Other: _____

Secondary (defect size)

- ☐ M51.A0
- ☐ M51.A1
- ☐ M51.A2
- ☐ M51.A3
- ☐ M51.A4
- ☐ M51.A5

Other (symptoms)

- ☐ M51.06
- ☐ M51.16
- ☐ M51.17
- Other: _____

Procedure Information

Relevant disc level (L4-L5 or L5-S1)
(Please indicate left or right) _____

Facility Name _____

Facility Address _____

City/State: _____

Facility NPI #: _____

Facility TIN: _____

Facility Phone #: _____

Date and Time of Surgery: _____

If you have any questions completing this form, please contact the Patient Access team at (844) 288-7474 or, if known, contact your dedicated Patient Access team member.

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