Please complete and fax ALL clinical documentation to:
Main Fax Line: (855) 803-9485 Secondary Fax Line: (855) 803-9484

Patient Information			
Patient Name:	**Gender:** ☐ **M** ☐ **F**	**D.O.B:**	
Address:	**City:**	**State:**	**Zip:**
Home Telephone Number:	**Cell Number:**	**Work Number:**	
Social Security Number:	**Email Address:**		
Height_____ **Weight**_____	**BMI**_____	**Knee: Right** ☐ **Left** ☐	
Diagnosis / ICD – 10 Codes: ☐ _____ **Primary Diagnosis** ☐ _____ **Secondary Diagnosis** ☐ _____ **Other**			
Facility Where Implantation will be performed:			
Facility Name:			
Facility Address:	**City:**	**State:**	**Zip:**
Facility Telephone Number:			
Facility NPI #:	**Facility Tax ID #:**		
Surgery Date or Expected Timeframe:			
Additional Procedures to be Performed with MACI– CPT code(s) other than 27412: ☐**27418** ☐**29888** ☐**27425** ☐**27420** ☐**29868** ☐**27457** ☐**27428** ☐**Other**_____ ☐**None**			
Hospital Stay: ☐ **Inpatient #** _____**of days** ☐ **Outpatient** ☐ **23 hour** **Facility Materials Management/Medical Billing Contact Info:**			
Physician Information:			
Office Name:			
Address:	**City:**	**State:**	**Zip:**
Implanting Physician Name:			

Physician NPI #:	**Physician Tax ID #:**
Office Staff Contact Name:	**Office Contact Number:**
Office Fax Number:	**Office Contact Email Address:**

Insurance Information - Primary:		
Subscriber Name:		**Subscriber D.O.B:**
Insurance / Work Comp Name:		**Insurance Contact:**
Insurance Contact Number:		
Insurance ID / Claim #:	**D.O.I.**	**Group #:**

Insurance Information - Secondary:	
Subscriber Name:	**Subscriber D.O.B:**
Insurance Name:	**Insurance Contact:**
Insurance Contact Number:	
Insurance ID #:	**Group #:**

Clinical information needed:

- ☐ **Copy of front and back of insurance card**
- ☐ **Operative reports:** ***please include all from previous surgeries***
- ☐ **All progress notes from office visits:** ***please include initial visit***
- ☐ **MRI / X-Ray reports**
- ☐ **Physical Therapy notes:** ***minimum of 2 months***
- ☐ **Scope Photos**
- ☐ **Location and SIZE of Defect(s) to be treated with MACI _____**
- ☐ **If Patella and/or Multiple Defects, verify medical policy includes in criteria. If not, include Letter of Medical Necessity (LOMN), specific to Patient.**
- ☐ **Is Vericel representative (CTS) needed at the implant procedure Yes ☐ No ☐**

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MACI® – Number of Implants Determination

MACI® (autologous cultured chondrocytes on porcine collagen membrane) is manufactured as a single 5 cm x 3 cm cellularized scaffold. Final shipment is prepared with one (NDC 69866-1030-1) or two (NDC 69866-1030-2) implants.

Based on number and size of lesions to be treated, indicate below how many implants will be required for this case. Please note this information will be part of the insurance authorization process.

Defect Description:

Number of Defects to Be Treated: 1

Defect Site 1:	Knee (R / L): Right	Defect 1 location:	Lesion 1 dimensions (cm, L x W):	Size of lesion 1 (cm^2):
Defect Site 2 *(if applicable)*:	Knee (R / L): Right	Defect 2 location:	Lesion 2 dimensions (cm, L x W):	Size of lesion 2 (cm^2):
Defect Site 3 *(if applicable)*:	Knee (R / L): Right	Defect 3 location:	Lesion 3 dimensions (cm, L x W):	Size of lesion 3 (cm^2):
Defect Site 4 *(if applicable)*:	Knee (R / L): Right	Defect 4 location:	Lesion 4 dimensions (cm, L x W):	Size of lesion 4 (cm^2):

MyCartilage® Care Guidance:

Cumulative Lesion Area (cm^2, sum from right column in table above):

1 Defect to be Treated	
# of Implants	**Cumulative Lesion Area**
1	Equal to or less than 14 cm^2
2	Greater than 14 cm^2

2 or 3 Defects to be Treated	
# of Implants	**Cumulative Lesion Area**
1	Equal to or less than 10 cm^2
2	Greater than 10 cm^2

For patients that do not fall within above parameters please consult with your Vericel representative on how many implants to order.

***Number of MACI Implants*:**

Selection	# of Implants	Product
☐	**1**	NDC 69866-1030-1)
☐	**2**	NDC 69866-1030-2)

I have read and understand the MACI production and shipping logistics. _____ (***physician please initial here***)

Please contact your MyCartilage Care® Representative at 877-872-4643 if you have any questions or need further information.