Barrigel™
CONTROL MATTERS

Barrigel™ Rectal Spacer Coverage Summary Checklist

Patient Name: Date:

MRN: Physician:

Health Plan Name:

Covered Codes

Prior Authorization Requirements

Coverage Criteria	Enter patient result for each criterion	Page #

All medical necessity criteria should be documented in the medical record. Reference complete medical policies available on the health plan website.

**A health plan's medical necessity criteria may not match the current FDA indication for the Barrigel Rectal Spacer.*

Disclaimer:
This document and the information contained herein is for general information purposes only and is not intended, and does not constitute, legal reimbursement, business, clinical or other advice. Furthermore, it does not constitute a representation or guarantee of reimbursement, and it is not intended to increase or maximize payment by any payer. Nothing in this document should be construed as a guarantee by Teleflex regarding reimbursement or payment amounts, or that reimbursement or other payment will be received. The ultimate responsibility for obtaining payment/reimbursement remains with the customer. This includes the responsibility for accuracy and veracity of all claims submitted to third-party payers. In addition, the customer should note that laws, regulations, and coverage policies are complex and are updated frequently, and, therefore, the customer should check with its local carriers or intermediaries often and should consult with legal counsel or a financial or reimbursement specialist for any questions related to billing, reimbursement or any related issue. This information does not guarantee coverage or payment at any specific level and Teleflex does not advocate or warrant the appropriateness of the use of any particular code.

Teleflex
Empowering the future of healthcare