NeuroStar Care Connection Enrollment Form / Statement of Medical Necessity

Phone number: 877.622.2867
Please fax completed form to 866.307.1339

Program Services

The NeuroStar Care Connection can provide several services for NeuroStar patients and providers. These include benefit verification (checking a patient's health plan for coverage), prior authorization assistance (researching the prior authorization requirements of the patient's health plan, submitting for prior authorization and follow up), researching the appeals process for prior authorization denials and submitting appeals paperwork, researching the appeals requirements and helping with the appeals process for denied claims.

Prescribing Physician Information

Name: _____ NPI Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cellular Phone: _____

Patient's Primary Language: English _____
Other (specify) _____

Patient Insurance Information

Please attach a copy – front & back of insurance card(s) if available.

Primary Insurance: _____
Subscriber: _____ Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Other
Subscriber's ID Number: _____ Insurance Phone Number: _____
Group Number: _____ Is Provider Contracted with This Insurance?
☐ Yes ☐ No

Secondary Insurance: _____
Subscriber: _____ Relationship to Subscriber
☐ Self ☐ Spouse ☐ Other
Subscriber's ID Number: _____ Insurance Phone Number: _____
Group Number: _____ Is Provider Contracted with This Insurance?
☐ Yes ☐ No

Patient Medical Information

Primary Diagnosis: _____ (ICD-9 code)

Secondary Diagnosis: _____ (ICD-9 code)

Comorbidities

☐ 293.89 Anxiety Disorder
☐ Diabetes
☐ Chronic Pain
☐ 300.00 Anxiety Disorder NOS
☐ Cardiovascular Disease
☐ Other _____
☐ Fibromyalgia
☐ Parkinson's Disease

Treatment History

Please complete the following section or attach a complete initial evaluation or psych consult document describing the details of the patient's treatment history and current functional status.

Medications: Please write legibly. For use with Reimbursement Process.

Psychotropic Medications *(write in)*	History P = Prior use in current episode C = Current medication F = Failed to reach remission *(circle all that apply)*	Max Dosage/Duration *(write in)*	Reason for Discontinuation L= Lack of efficacy I = Intolerance *(circle all that apply)*
1. _____	P C F	_____	L I
2. _____	P C F	_____	L I
3. _____	P C F	_____	L I
4. _____	P C F	_____	L I
5. _____	P C F	_____	L I
6. _____	P C F	_____	L I
7. _____	P C F	_____	L I

Electro Convulsive Therapy

Current episode: # of treatments: _____ Treatment result (circle one): No Response Partial Response Remission

Prior episode: # of treatments: _____ Treatment result (circle one): No Response Partial Response Remission

Orders

TMS Therapy: Anticipated # of Acute Treatments: _____

Anticipated # of Taper Treatments: _____

Anticipated Start Date: _____

Site of Service for Treatment:

☐ Physician Office ☐ Inpatient Psychiatric Hospital ☐ Outpatient Psychiatric Hospital

☐ Acute Inpatient Hospital ☐ Hospital Outpatient ☐ Other

PHYSICIAN CERTIFICATION

I verify that the patient and prescriber information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed NeuroStar TMS Therapy based on my professional judgment of medical necessity. I authorize Neuronetics or its affiliated companies, agent or subcontractors to perform any steps necessary to obtain reimbursement for NeuroStar TMS Therapy, including but not limited to insurance verification and case assessment. I understand that Neuronetics or its affiliated companies, agents or subcontractors may need additional information, and I agree to provide it as needed for the purposes of reimbursement.

Physician's Full Signature: _____ Date: _____

PATIENT AUTHORIZATION

In order for me to obtain reimbursement support services under the NeuroStar Care Connection Program, I understand that Neuronetics, its affiliates and authorized agents administering the program (including third party administrators) will need to review, use and disclose information about me, my health insurance coverage, and my medical diagnosis and treatment (including my use of or need for NeuroStar TMS Therapy). I request and authorize my psychiatrist and other healthcare professionals ("Doctor(s)") and my health plan or insurance company ("Insurer(s)") to give Neuronetics, its affiliates and authorized agents administering the program (including third-party administrators) information about me, my health insurance coverage, and my medical diagnosis and treatment (including my use of or need for NeuroStar TMS Therapy). This information can include spoken or written facts about my health and payment benefits, as well as copies of records from Doctor(s) or Insurer(s) about my health or healthcare. I understand that I may revoke this Authorization by sending a written notice to my Doctor(s) and Neuronetics. Revocation of this Authorization will be valid when received by my Doctor(s) and Neuronetics, except to the extent that my Doctor(s) and Neuronetics have already taken action relying on this Authorization. I also understand that my revoking this Authorization will not affect my health care treatment or enrollment under a health plan. I also understand the information disclosed because of this Authorization may be re-disclosed by the recipient and may not be protected by the federal privacy regulations. Neuronetics is required by contract to protect the confidentiality of this information. I authorize Neuronetics, its affiliates and authorized agents administering the program (including third party administrators) to use the information described above for purposes of obtaining reimbursement for NeuroStar TMS Therapy from my group health plan/Insurer. This authorization expires one year from the date below.

Patient's Full Signature: _____ Date: _____

If signed by a representative, please describe representative's authority to act on behalf of the patient. _____
Please attach a copy of the representative appointment document if applicable.