



NeuroStar Care Connection
Patient Enrollment Form

Terms and Conditions of Enrollment

To enroll a patient to receive reimbursement case management services from the NeuroStar Care Connection, the following checklist items must be completed. If any of these items are not completed or supplied, the enrollment process will not begin and you will receive an incomplete enrollment process notice requesting the missing information. No efforts to secure reimbursement for this patient will start until all sections of this form are completed and the attachments listed below have been supplied to NeuroStar Care Connection staff.

Patient Enrollment Checklist - Check each when completed

_____ **Enrollment Form is completed, including:**

- Pages 1, 2, 3 and 4 of the enrollment form have been completed.
- The patient has signed the Patient Enrollment Form on page 2.
- The prescribing psychiatrist has signed the Statement of Medical Necessity on page 4.

_____ **Psychiatric Evaluation:** The patient's psychiatric evaluation notes resulting in your professional decision to recommend NeuroStar TMS Therapy for this patient will be faxed with this enrollment form. (Check when faxed with the enrollment form.)

_____ **Safety Screening:** A safety screening has been completed and the patient is medically appropriate for NeuroStar TMS Therapy. (Check when completed.)

_____ **Patient Commitment:** The patient will assist NeuroStar Care Connection (NCC) during the insurance reimbursement process by completing any necessary forms or providing additional information pertinent to the case. NCC is committed to providing support for cases that meet NCC program guidelines. NCC will work with the provider and/or the patient to meet the requirements of individual insurance carriers, which vary by patient plan.

The patient understands that the enrollment form does not represent or replace any financial arrangements and liability forms that are established between a provider and a patient. Any specific information and guidelines regarding the provider's or patient's responsibilities in terms of charges and payments should be determined before NCC's services are requested. It is the responsibility of the provider and/or patient to check with the insurance carrier and provider contract, if applicable, regarding coverage policy guidelines and any specific terms.

The patient understands that there is no guarantee of coverage and payment from his/her insurance carrier, even if an approval has been obtained through a prior authorization or claims appeal. Final determination of coverage and payment will be determined during the claims process and is contingent upon medical necessity, the patient's individual plan and the individual payer's coverage guidelines. (Patient initials required on the line.)



NeuroStar Care Connection Program
1650 South Amphlett Blvd., Suite 300
San Mateo, CA 94402
Tel: 1-877-NCC2TMS
(1-877-622-2867)

Fax: 1-866-307-1339
www.NeuroStar.com



NeuroStar Care Connection™

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TMS Physician Information (for physician completing this form)

Name: _____ NPI #: _____ Tax ID #: _____

Facility or Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Email Address: _____ Name of Office Contact: _____

Who will be submitting claims to insurance? Office Will Submit Claim Patient Will Submit Claim

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

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

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

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

Primary Insurance: _____ Insurance Phone #: _____

Subscriber: _____ Subscriber ID #: _____

Relationship to Subscriber: Self Spouse Other Group #: _____

Is Provider Contracted with This Insurance? Yes No

Secondary Insurance: _____ Insurance Phone #: _____

Subscriber: _____ Subscriber ID #: _____

Relationship to Subscriber: Self Spouse Other Group #: _____

Is Provider Contracted with This Insurance? Yes No

Behavioral Health insurance company if different from primary health insurance: _____

Check one: Patient will start TMS Therapy without insurance approval Patient will wait for insurance approval before starting TMS Therapy

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.

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.



STATEMENT OF MEDICAL NECESSITY

Patient Initials: _____ Page 1 of 2

Please fax completed Statement of Medical Necessity to : 1-866-307-1339

Statement of Medical Necessity: Patient Name: _____

Insurance ID #: _____ Patient Date of Birth: _____

Patient Medical Information

Check all ICD-9 codes that apply. (If using more than one diagnosis, please circle the primary diagnosis.)

- ICD-9 codes: 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.26, 296.30, 296.31, 296.32, 296.33, 296.34, 296.35, 296.36, 296.82, 311, Other

Comorbidities

- Comorbidities: 293.89 Anxiety Disorder, 300.00 Anxiety Disorder NOS, Fibromyalgia, Diabetes, Cardiovascular Disease, Parkinson's Disease, Chronic Pain, Other

Treatment History - Current Episode

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

Medications in current episode - Please write legibly. For use with Reimbursement Process.

Table with 4 columns: Psychotropic Medications, History (P, C, F), Max Dosage/Duration, Reason for Discontinuation (L, I). Rows 1-7.

Electroconvulsive Therapy

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

Psychiatric Hospitalizations # of days _____ Dates/Year _____

Name of Hospital: _____

Psychotherapy

- Is patient currently in psychotherapy? Yes No
Has patient been treated with psychotherapy in current depressive episode? Yes No
Has patient ever received cognitive therapy for treatment of depression? Yes No

Symptoms in Current Episode

- Symptoms: Anhedonia, Cognitive impairment, Interpersonal withdrawal, Trouble sleeping, Weight change, Suicidal ideation, Work performance impacted, Irritability, Fatigue, Suicide planning, Other



Statement of Medical Necessity: Continued

Symptoms in Current Episode

Four horizontal lines for writing symptoms.

Treatment History - Prior Episode

Psychiatric hospitalizations

of days _____ Dates/Year _____

Name of Hospital: _____

Medications used in past episodes

- Grid of medication checkboxes including Amitriptyline, Duloxetine, Escitalopram, Fluoxetine, Venlafaxine, Mirtazapine, Anafranil, Pamelor, Fluvoxamine, Sertraline, Trazadone, Aripiprazole, Citalopram, Tofranil, Paroxetine, Bupropion, Desvenlafaxine, and Other.

Electroconvulsive Therapy

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

Orders: Transcranial Magnetic Stimulation

TMS Therapy Treatment Planning: CPT Code 90867 _____

Anticipated # of Acute Treatment Sessions: CPT Code 90868 _____

Anticipated Start Date: _____

Site of Service for Treatment:

- Grid of site of service checkboxes: Physician Office, Acute Inpatient Hospital, Inpatient Psychiatric Hospital, Hospital Outpatient, Outpatient Psychiatric Hospital, 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 management. 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: _____