NeuroStar® Advanced Therapy

Benefits Investigation Access Form

Please fax completed form to:
1(800)790-8590

(to be used when utilizing ***NeuroStar Reimbursement Services*** for the Benefits Investigation)

TMS Physician Information (for the treating physician completing this form)

Name: Billing NPI #: Billing Tax ID #:

Facility or Practice Name:

Address: City: State: Zip:

Phone: Fax:

TMS Coordinator: Email:

Other Key Reimbursement Contact: Is your office contracted with this insurance? Yes ☐ No ☐

Secondary Plan? Yes ☐ No ☐ If Out of Network, would you prefer both In and Out of Network Benefits? Yes ☐ No ☐

Behavioral Health Insurance Company if different than the primary health insurance:

Are you contracted with the Behavioral Health Insurance Company if different than the primary health insurance? Yes ☐ No ☐

Patient Information

Patient Name: Date of Birth:

Address: City: State: Zip:

Home Phone: Cell Phone:

Patient Insurance Information

Please attach a copy of the patient's insurance card(s) – front and back

Primary Insurance: Secondary Insurance:

Primary Insurance Phone Ext: Secondary Insurance Phone: Ext:

Subscriber: Subscriber:

Subscriber ID #: Subscriber ID #:

Group #: Group #:

Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐ Relationship to Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

Patient Authorization

In order for me to obtain reimbursement support services under the NeuroStar Reimbursement Support program, I understand that Neuronetics, its affiliates and authorized agents administering the program (including third party administrators) ("Neuronetics") will need to receive, 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 physician and other healthcare professionals ("Doctor(s)") and my health plan or insurance company ("Insurer(s)") to give Neuronetics information about me, my health insurance coverage, and my medical diagnosis and treatment (including my use of or need to use 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/or 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 or state privacy regulations. Neuronetics may be required by contract to protect the confidentiality of this information but otherwise does not assume any responsibility for the information submitted. Neuronetics is providing its services "AS IS" without representations or warranties of any kind, express or implied, and cannot and does not accept any liability including for any inability to obtain coverage or reimbursement for me.

In no event shall Neuronetics be liable for any direct, indirect, consequential, incidental, special or exemplary damages of any kind or nature arising out of the services. I hereby authorize Neuronetics to use the information described above for purposes of assisting to gain access and reimbursement for NeuroStar TMS Therapy from my group health plan/Insurer and to otherwise support my care.

All reimbursement information provided by Neuronetics is for general guidance only. It does not represent a statement, promise or guarantee by Neuronetics concerning levels of reimbursement, payment, or charge, if any. Coverage and payment for NeuroStar TMS Therapy is based on various factors, including but not limited to; medical necessity, the patient's specific benefits plan, and individual insurance company's policies and guidelines. It is the responsibility of the physician and patient to be knowledgeable of the applicable guidelines.

Patient's Full Signature or Verbal Permission:

NeuroStar® Advanced Therapy

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Patient Name: _____ Patient Date of Birth: _____

Subscriber ID #: _____

Orders: Diagnosis (ICD-10) Codes

ICD-10 Codes: ***(If using more than one diagnosis, please circle the primary diagnosis)***

☐ F32.9 ☐ F32.0 ☐ F32.1 ☐ F32.2 ☐ F32.3 ☐ F32.4 ☐ F32.5 ☐ F33.9 ☐ F33.0 ☐ F33.1

☐ F33.2 ☐ F33.3 ☐ F33.41 ☐ F33.42 ☐ F32.8

Please Note: The CPT and ICD-10 Coding information listed above represents no statement, promise or guarantee by Neuronetics concerning levels of reimbursement, coverage and payment. Certain guidelines apply to the reporting of the above codes. Please refer to the proper coding resources and the payer's individual guidelines. Individual payer guidelines may vary according to coding and coverage. It is the responsibility of the provider to determine and submit the appropriate codes for the services rendered.

Site of Service for Treatment:

☐ Physician Office ☐ 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 to take the steps necessary to gain information for obtaining insurance verification. I understand that Neuronetics may need additional information, and I agree to provide it as needed for the purposes of reimbursement.

Physician's Full Signature: _____ Date: _____