



NeuroStar Care Connection™

Enrollment Form

(General Services)

NeuroStar Care Connection Program
1650 South Amphlett Blvd., Suite 300
San Mateo, CA 94402

Copyright ©2011 Neuronetics, Inc. All rights reserved.

Tel: 1-877-NCC2TMS (1-877-622-2867)
Fax: 1-866-307-1339
www.NeuroStar.com

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

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

Facility or Practice Name: _____

Address: _____

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

Email Address: _____ Name of Office Contact: _____

Is Provider Contracted with This Insurance? Yes No Secondary Plan: Yes No

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

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 #: _____

Secondary Insurance: _____ Insurance Phone #: _____

Subscriber: _____ Subscriber ID #: _____

Relationship to Subscriber: Self Spouse Other Group #: _____

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.

Patient Name: _____ Patient Date of Birth: _____

Insurance ID #: _____

Orders: Procedural (CPT) and Diagnosis (ICD-9) Codes*

Please check all codes that apply to the patient's specific case.

CPT Codes:

- CPT Code 90867: Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
- CPT Code 90868: Therapeutic repetitive transcranial magnetic stimulation (TMS) Treatment; subsequent delivery and management, per session
Please indicate the anticipated # of TMS sessions _____
- CPT Code 90869: Subsequent motor threshold re-determination with delivery and management

ICD-9 Codes: (If using more than one diagnosis, please circle the primary diagnosis)

- 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 _____

Co-morbidities

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

Please Note: The CPT and ICD-9 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 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 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: _____

Terms and Conditions of Enrollment

To enroll a patient to receive General Services 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 - To be checked when completed by the treating physician

- _____ Enrollment Form is completed, including:
- All Pages of this enrollment form have been completed.
 - The patient has signed the Patient Authorization section on page 2.
 - The prescribing psychiatrist has signed the Physician Certification section on page 3.

_____ **NCC Case Manager/Patient Contact Permission:**
 There will be certain instances when a NCC Case Manager will need to contact the physician’s office and the patient at anytime during the course of a case. The physician’s office and the patient are giving NCC permission to contact the patient directly without having to notify the physician first. If either party is not in agreement, please indicate specific instructions for the NCC Case Manager to follow for this specific case:

Specific Instructions:

_____ **Patient Commitment:** The patient understands that the enrollment into the NCC Program for General Services 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 the 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 this 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