NeuroStar Reimbursement Support

Enrollment Form

NeuroStar
Reimbursement Support
3222 Phoenixville Pike
Malvern, PA 19355-9600

Tel: 1-877-622-2867
Fax: 1-800-790-8590
Email: reimbursementsupport@neuronetics.com
www.NeuroStar.com

50-00157-000 Rev C

Patient Enrollment Form

Patient Initials: _____

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

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

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

Facility or Practice Name: _____

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

Phone: _____ Fax: _____

TMS Coordinator: _____ Other Key Reimbursement Contact: _____

Is your office contracted with this insurance? ☐ Yes ☐ No Secondary Plan? ☐ Yes ☐ No

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

Patient Information

Patient Name: _____ Date of Birth: _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Primary Insurance: _____ Subscriber: _____

Subscriber ID #: _____ Group #: _____

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

Secondary Insurance: _____ Subscriber: _____

Subscriber ID #: _____ Group #: _____

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

Patient Authorization

In order for me to obtain reimbursement support services under the NeuroStar Care Connection Program or Neuronetics 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 psychiatrist 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: _____ 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.

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

Patient Name: _____ Patient Date of Birth: _____

Subscriber 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

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 ☐ 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: _____

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Patient Enrollment Checklist

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.

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