



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. Please refer to the program brochure for details.

Physician Type – The physician completing this form is: (check one)
[] Treating Physician
[] Referring Physician – (If referring physician, list treating physician name and contact info)
Treating Physician Name:
Address:
Phone #:

Physician Information – (for physician completing this form)
Name: NPI #: (only needed if you will be billing for TMS Therapy services)
Address:
City: State: Zip: Phone: Fax:
Email Address: Name of Office Contact:
Will the office be submitting claims to insurance or will this be the patient responsibility? [] Office [] Patient

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: Insurance Phone #: Subscriber ID #:
Subscriber: Relationship to Subscriber: [] Self [] Spouse [] Other
Group #: Is Provider Contracted with This Insurance? [] Yes [] No
Secondary Insurance: Insurance Phone #: Subscriber ID #:
Subscriber: Relationship to Subscriber: [] Self [] Spouse [] Other
Group #: Is Provider Contracted with This Insurance? [] Yes [] No

Patient Medical Information –
Check all ICD-9 codes that apply. (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
Comorbidities
[] 293.89 Anxiety Disorder [] 300.00 Anxiety Disorder NOS [] Fibromyalgia
[] Diabetes [] Cardiovascular Disease [] Parkinson's Disease
[] Chronic Pain [] Other



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			Max Dosage/Duration (write in)	Reason for Discontinuation	
	P = Prior use in current episode	C = Current medication	F = Failed to reach remission		L = Lack of efficacy	I = Intolerance
	(circle all that apply)				(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.