VNSTherapy®

VNS Therapy® Eligibility and Education Form

Fax completed form to (888)-577-7205

REQUESTING PHYSICIAN INFORMATION

Physician Name: _____ Physician NPI#: _____ Physician Phone #: _____

Surgeon Name: _____ Surgeon NPI#: _____ Surgeon Phone #: _____

Implanting Hospital: _____ Date of Surgery: ☐☐☐

Comments: _____

PATIENT INFORMATION

Patient Name (Last): _____ (First): _____

Address: _____ Phone #: _____ City, State, Zip : _____

Sex: ☐ Male ☐ Female SSN: _____ Date of Birth: ☐☐☐

Guardian/Contact: _____ Email: _____

Group Home Name: _____

Principle Diagnosis (please check one):

- ☐ G40.211 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
- ☐ G40.219 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
- ☐ G40.011 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, with status epilepticus
- ☑ G40.019 Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
- ☐ G40.111 (Attacks without alteration of conscious) Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
- ☐ G40.119 (Attacks without alteration of conscious) Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
- ☐ Other (please describe): _____

Insurance information (Patient Face Sheet) Attached ☐ YES ☐ NO

	PRIMARY INSURER	SECONDARY INSURER
Name of Insurance Co.		
Phone of Insurance Co.		
Subscriber's Name (if different)		
Employer/Plan Name		
Policy No.		
Group No.		
Provider Insurer ID No.		
Does physician participate with above insurer?	☐ YES ☐ NO	☐ YES ☐ NO

I hereby authorize and request Cyberonics, Inc. to 1) release the above information to the insurers identified above, to assess coverage of vagus nerve stimulation implants and related health care services, and 2) have a VNS Therapy Nurse Case Manager contact the above-listed patient to conduct education on VNS Therapy. I understand that Cyberonics representatives will keep this information confidential and will use it only for these purposes.

Physician Signature _____ Date ☐☐☐

PLEASE HAVE THE BELOW SECTION SIGNED BY THE PATIENT/LEGAL GUARDIAN IF AUTHORIZATION TO RELEASE PHI IS NOT ON FILE WITH THE PHYSICIAN'S OFFICE.

I hereby authorize the above-noted Physician to use and disclose protected health information (PHI) from my records. I understand that PHI will be disclosed to Cyberonics, Inc. for the purposes of insurance verification and preauthorization; evaluating whether I am a candidate for Vagus Nerve Stimulation (VNS) Therapy; and contacting me for purposes of providing education regarding VNS Therapy. I understand that the records to be disclosed to Cyberonics include insurance information, as well as my name, phone number, diagnostic information, and medical history. I understand that I may revoke this authorization in writing at any time (except to the extent that my Physician has already relied on this authorization) by sending or faxing a written notice of revocation to my Physician. I understand that this Authorization, unless sooner revoked, expires five (5) years from the date I sign the Authorization.

Print Name _____

Patient / Legal Guardian Signature _____ Date ☐☐☐

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