VNSTherapy®

VNS Therapy Patient Eligibility, Education and Authorization 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: _____ City, State, Zip : _____ Phone #: _____

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 LivaNova to 1) release the above information to the insurers identified above and assess coverage of vagus nerve stimulation implants and related health care services, (2) provide for ongoing maintenance and consultation as it relates to patient's VNS Therapy implantable device; and (3) have a VNS Therapy Nurse Case Manager contact the above-listed patient to conduct education on VNS Therapy. I understand that the information provided is not considered a complaint/malfunction unless otherwise noted in the box below.

☐ By checking this box, I am indicating that the medical records contain a report of a device complaint/malfunction or adverse event associated with VNS Therapy.

Physician Signature _____ Date ☐☐☐

PLEASE HAVE THE BELOW SECTION SIGNED BY THE PATIENT/LEGAL GUARDIAN

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 LivaNova and its agents for the purposes of insurance verification, preauthorization, predetermination, PCP referral assistance, and appeals; evaluating whether I am a candidate for Vagus Nerve Stimulation (VNS) Therapy; for ongoing maintenance and consultation by LivaNova regarding VNS Therapy; and contacting me for purposes of providing education regarding VNS Therapy. I understand that the records to be disclosed to LivaNova include, but are not limited to, insurance information, my name, phone number, diagnostic information, programming history, and medical history. While I understand that LivaNova commits to maintain the confidentiality of this information, I recognize that any disclosure of information carries the potential for unauthorized re-disclosure which may not be protected by applicable privacy laws. I understand that I may revoke this Authorization in writing at any time (except to the extent that my Physician or LivaNova has already relied on this Authorization) by sending or faxing a written notice of revocation to my Physician and LivaNova. I understand that this Authorization, unless sooner revoked, expires fifteen (15) years from the date I sign the Authorization. I may refuse to sign this form. Such refusal will not in any way adversely affect my treatment or physician-patient relationship.

Print Name _____

Patient / Legal Guardian Signature _____ Date ☐☐☐

LivaNova USA, Inc.
100 Cyberonics Boulevard
Houston, Texas 77058
Tel: +1.800.332.1375
Fax: +1.281.218.9332
www.VNSTherapy.com

LivaNova Belgium NV
Ikaroslaan 83
1930 Zaventem
Belgium
Tel: +32.2.720.95.93
Fax: +32.2.720.60.53

LivaNova
Health innovation that matters