Acessa Patient Support Program

PATIENT ENROLLMENT FORM

The purpose of this form is to gather volunteered information about a potential Acessa candidate, their provider and any other relevant information to determine insurance coverage. The information on this form must be volunteered by the patient and consented to be shared. By submitting this form the patient and physician give the right to receive email notification directly from an Acessa representative.

Please fax the completed form along with a copy of the front / back of patient's insurance card and all supporting documentation to: 877-225-0643

For Live Assistance Call: 866-473-4895
insurance@accesahealth.com

Date Submitted: _____/_____/_____/

PLEASE PRINT LEGIBLY

Provider Information

Contact Person:		**Title:**	
Prescribing Physician Name:	**Specialty:**	**Practice Name:**	
Practice Address:	**City:**	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**		
Email Address for Contact Person:	**Preferred Contact Method:** ☐ Phone ☐ Email ☐ Fax		
Prescribing Physician Rendering NPI:	**Tax ID Number:**		

Patient Information (U.S. Residents Only)

Patient Name:	**Phone #:**	**Social Security #:**	**Date of Birth:**
Street Address:	**City:**	**State:**	**Zip Code:**
Patient's Email Address:			

Insurance Information

Primary Insurance Carrier Name (from insurance card, not EMR):		**Insurance Phone #**
Plan Type: ☐ HMO ☐ PPO ☐ Government	**Is physician in network with insurance carrier?** ☐ Yes ☐ No	
Member ID #:	**Group #:**	**Policy Holder:**

Medical Information

ICD-10-CM Diagnosis Code(s):

- ☐ D25.1 - Intramural leiomyoma of uterus (includes interstitial leiomyoma of uterus)
- ☐ D25.2 – Sub-serous leiomyoma of uterus (includes sub-peritoneal leiomyoma of uterus)
- ☐ Others (please list ICD10): _____

CPT Code(s):

- ☐ 58674 – Laparoscopy, surgical, ablation of uterine fibroid(s), including intraoperative ultrasound guidance and monitoring, radiofrequency. (EFFECTIVE 01/01/2017)
- ☐ Others (please list, including CPT codes)

_____

Please Complete:

1. Site of Service for Planned Procedure(s): ☐ Hospital ☐ ASC

2. Site of Service Facility:

Facility NPI _____ Facility Tax ID _____

3. Procedure Location Facility Name (Please use full name):

_____

4. Procedure Location Facility Address/Phone # (Street Address, City, State, Zip):

_____

5. Anticipated Date of Procedure: _____

Additional Information

Patient is: ☐ New Patient ☐ Existing Patient ☐ Referral Patient **Referring Provider:** _____

Is the patient new to the practice and seeking information about the Acessa procedure? ☐ Yes ☐ No

Please provide any additional information that will assist with the resolution of this case.

_____

_____

We will need the following for insurance medical review, did you remember to attach:

- ☐ All available physician visit notes regarding treatment of uterine fibroids
- ☐ Any ultrasounds, MRIs and/or lab reports showing size of uterine fibroids
- ☐ Copy of the front and back of patient's insurance card(s)

In recognition of ongoing post-market clinical study of the Acessa procedure in the U.S., disclosure of all clinical trial participation is required. Through signature on this form, this office is confirming that the patient identified on this form has NOT consented or enrolled in any clinical study. Reimbursement support services for this patient are restricted to non-clinical study services as defined by the FDA regulations and as identified under the www.clinicaltrials.gov website.

Name: _____

Signature: _____ **Date:** _____