CONTOUR℠NEXT Reimbursement Support Program
Authorization Form

To enroll, please complete, sign and submit this form by selecting the **SUBMIT** button.
You may also select the **PRINT** button option to print the completed form and submit via e-mail at **Reimbursement@ContourNextHelp.com,** or via fax at **866.296.1437.** For help, call **1-866-296-1436.**

TO ENSURE TIMELY SERVICE, PLEASE FILL OUT ALL FIELDS ON BOTH PAGES.

○ **SUBMIT FORM** ○ **PRINT FORM**

PRESCRIBER INFORMATION

Prescriber's Name ______ Phone ______

DEA ______ NPI ______ TAX ID ______

Office Contact ______ Email ______

Address ______ City ______ State ______ Zip ______

PATIENT INFORMATION

First Name ______ Last Name ______ Date of Birth ______

Phone ______ Email ______

Address ______ City ______ State ______ Zip ______

INSURANCE INFORMATION

Primary Insurance Plan Name ______

Primary Insurance Policy Number ______

Prescription Insurance Plan Name ______

Prescription Insurance Policy Number ______

CLINICAL INFORMATION

Prescription Information

CONTOUR®NEXT Test Strips ☐ 50-count ☐ 100-count ☐ Other Quantity ______

Number of tests per day ______ Directions for Use ______

PLEASE COMPLETE PAGE 2 →

CONTOUR℠NEXT Reimbursement Support Program

Authorization Form

To enroll, please complete, sign and submit this form by selecting the **SUBMIT** button.
You may also select the **PRINT** button option to print the completed form and submit via e-mail at **Reimbursement@ContourNextHelp.com,** or via fax at **866.296.1437.** For help, call **1-866-296-1436.**

TO ENSURE TIMELY SERVICE, PLEASE FILL OUT ALL FIELDS ON BOTH PAGES.

○ **SUBMIT FORM** ○ **PRINT FORM**

DIAGNOSIS & TREATMENT HISTORY

Diagnosis Code (Select One) ______

If other product(s) was/were used, please indicate

Is the patient on a compatible Medtronic Insulin Pump* ☐ Yes ☐ No

Does the patient use a Continuous Glucose Monitoring (CGM) system? ☐ Yes ☐ No

Is patient visually, physically, or functionally impaired? ☐ Yes ☐ No

---

AUTHORIZED CONSENT

By signing below, I certify that I have obtained a HIPAA authorization from the patient authorizing me to release the patient's protected health to third parties, as necessary, to effect the patient's treatment, payment, and Health Care operations as defined in HIPAA (45 CFR 164.506)

Prescriber's Signature ______ Date ______

PATIENT CONSENT (IF THERE IS NO HIPAA AUTHORIZATION ON FILE)

By signing this authorization, I, the patient, authorize my healthcare provider to use and/or disclose protected health information (PHI) related to CONTOUR®NEXT Test Strips from my health records and insurance information to WRB, on behalf of Ascensia Diabetes Care (Ascensia), as necessary for treatment and care coordination, and to obtain insurance coverage and reimbursement information for CONTOUR®NEXT Test Strips. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and will no longer be protected by federal privacy regulations. In carrying out these activities, WRB, on behalf of Ascensia, may relay information to health insurer(s), receive information from health insurer(s), and communicate such information to my healthcare provider. I understand that this authorization is voluntary and that I may refuse to sign this authorization.
I understand that my refusal to sign does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment.
I understand that I may revoke this authorization at any time provided that the information has not been disclosed. Information that has already been disclosed may be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following address: CONTOUR NEXT Reimbursement Support Program 4200 Lafayette Center Drive Chantilly, VA 20151. This authorization will remain in effect until revoked by me or until the end of my participation in the program.

Patient/Guardian Print Name ______ Date ______

Patient/Guardian Signature ______ Date ______

○ **SUBMIT FORM** ○ **PRINT FORM**

* The CONTOUR®NEXT LINK Meter is compatible with the MiniMed® 530G System with SmartGuard™ technology and with the MiniMed® Paradigm® REAL-Time Revel™ insulin pumps.

© 2016 Ascensia Diabetes Care. All rights reserved. Ascensia, the Ascensia Diabetes Care logo and CONTOUR are trademarks and/or registered trademark of Ascensia Diabetes Care. All other trademarks are the property of their respective owners. 07/16
PP-CN-LNK-US-0221

ASCENSIA
Diabetes Care

Contour next
Portfolio