Prescription and Enrollment Form

CONTOUR®NEXT SYNC Reimbursement Support

Prescribers: Please complete and sign this form.
Email to **Reimbursement@ContourNextHelp.com** or fax to **866-296-1437.** For help, call **866-296-1436.**

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

☐ **EMAIL FORM** ☐ **PRINT FORM**

PRESCRIBER INFORMATION

First Name | Last Name | Phone

DEA | NPI | TAX ID

Office Contact | Email

Address | City | State | Zip

Preferred Contact Method ☐ Phone ☐ Email ☐ Other (Please specify) _____

PATIENT INFORMATION

First Name | Last Name | Date of Birth

Phone | Email

Address | City | State | Zip

Patient Pharmacy of Choice | Phone

INSURANCE INFORMATION

Primary Insurance Plan Name | Primary Insurance Policy Number

Prescription Insurance Plan Name | Prescription Insurance Policy Number

PRESCRIPTION AUTHORIZATION Rx

Diagnosis Name/Code

CONTOUR®NEXT Test Strips | Quantity | Number of Refill(s)

Recommended Testing Per Day

Prescriber's Signature SIGN HERE | Date

Please attach all prescriptions on Official State Prescription form if mandated by individual state laws.

Envoy: Please Send Prescription Form (Page 1) to Pharmacy.

PLEASE COMPLETE NEXT PAGE

Prescription and Enrollment Form

CONTOUR®NEXT SYNC Reimbursement Support

Prescribers: Please complete and sign this form.
Email to **Reimbursement@ContourNextHelp.com** or fax to **866-296-1437.** For help, call **866-296-1436.**

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

CLINICAL INFORMATION

Co-morbidities

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

Is this patient on insulin pump therapy? ☐ Yes ☐ No

Is this the first time the patient will be using an insulin pump? ☐ Yes ☐ No

Please Specify Pump Model

Does the patient use a Continuous Glucose Monitoring System (CGMS)? ☐ Yes ☐ No

Please Specify CGM Model

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

AUTHORIZED CONSENT (PRESCRIBER SIGNATURE REQUIRED)

By signing below, I certify that I have obtained a valid HIPAA authorization form from the patient authorizing me to release the patient's protected health information to Envoy Health, on behalf of Ascensia Diabetes Care, as necessary, to obtain insurance coverage and reimbursement information for CONTOUR®NEXT products and to forward the above prescription, by fax or other mode of delivery to the pharmacy chosen by the patient.

Prescriber's Signature SIGN HERE 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 Envoy Health, a Diplomat company, "Envoy Health", 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, Envoy Health, 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 SYNC Reimbursement Support, 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

☐ **EMAIL FORM** ☐ **PRINT FORM**

PP-CNL-2.4-US-0537