



Print Form

Reimbursement Support Program Enrollment Form

Phone: 1-888-461-2255 (Option 3) Fax: 1-888-343-3275
9:00 AM - 6:00 PM Eastern Time Monday - Friday

PLEASE READ: Patient's written consent has been obtained to release patient information to this program to facilitate the insurance verification process: Yes No (If no, please obtain consent before submitting this form)

Physician Information

Physician Name: _____
Practice/Facility Name: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
Telephone: _____ Fax: _____
Email: _____
Name of Individual Completing Form: _____
Tax ID: _____ DEA: _____

Insurance Information (Primary)

Medicare Medicaid Commercial
 Worker's Compensation Champus/TriCARE

Insurance Information Detail (Primary)

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ ZIP: _____
Telephone: _____ Fax: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's SSN: _____
Relationship to Patient: _____
Policy #: _____ Group #: _____
Employer's Name: _____
Physician Insurance Provider/NPI #: _____
(Required for interaction with insurance company): _____
Is physician a participating or non-participating provider?
(Please check one): Participating Non-Participating

Treatment Information

Site of Service: Physician's Office ASC
 Hospital Outpatient Hospital Inpatient
 Other
Diagnosis Code 1: _____
Diagnosis Code 2: _____
(ICD-9 Code May Only Be Assigned By Physician)

Patient Information

Patient Name: _____
Sex: Male Female
Date of Birth: _____
SSN: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ ZIP: _____
Telephone: _____ Fax: _____
Email: _____

Insurance Information (Secondary)

Medicare Medicaid Commercial
 Worker's Compensation Champus/TriCARE

Insurance Information Detail (Secondary)

Name of Insurance Company: _____
Address: _____
City: _____ State: _____ ZIP: _____
Telephone: _____ Fax: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____
Policy Holder's SSN: _____
Relationship to Patient: _____
Policy #: _____ Group #: _____
Employer's Name: _____
Physician Insurance Provider/NPI #: _____
(Required for interaction with insurance company): _____
Is physician a participating or non-participating provider?
(Please check one): Participating Non-Participating

Treatment Information

EMG Code: _____
CPT Code: _____
Date of Service: (If known): _____
Patient Dosage: _____
Number of Vials: _____ Vial Sizes: _____





PLEASE READ DECLARATION BEFORE SIGNING

PATIENT DECLARATION

I certify that the information provided in this application is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Solstice Neurosciences LLC ("Solstice") Reimbursement Support Program. I hereby provide my consent to permit my physician to release patient identification, insurance and medical information about me to the Solstice Reimbursement Support Program including any other information necessary to evaluate my insurance coverage for MYOBLOC® (rimabotulinumtoxinB) Injection and to complete the verification process. I further provide my consent to permit the Program to obtain insurance coverage information from my employer or insurance company, and to obtain any other information about me necessary to complete the verification process, assess eligibility, verify continuing eligibility, or verify accuracy of any information provided in this application. I understand such information is for the sole use of Solstice, its representatives and/or agents for the purpose of assessing my insurance coverage for treatment with MYOBLOC. I understand that my information will not be shared with any third parties except as necessary for my participation in the Program, except as otherwise required by law. This authorization will remain in effect until I no longer need assistance from the MYOBLOC Reimbursement Support Program or until I revoke the authorization by calling a MYOBLOC Reimbursement Support Program representative at 888-461-2255 or by sending a fax to 888-343-3275 stating my revocation.

I understand that there is no guarantee that my insurance company will reimburse for MYOBLOC® (rimabotulinumtoxinB) Injections. I also understand that the Program reserves the right at any time, and without notice: to modify the form; to modify or discontinue any or all aspects of the Program; or to terminate assistance under the Program at any time.

Reimbursement services are available only for those patients being treated with MYOBLOC® (rimabotulinumtoxinB) Injection for a therapeutic condition for which there is a reasonable expectation for reimbursement from a third-party payer.

I have indicated my agreement with these terms by signing below.

Patient Name (Printed)

Patient Signature Date

PHYSICIAN DECLARATION

I agree to communicate Program information as provided by Solstice Neurosciences, LLC ("Solstice") to my patients upon request. I understand that there is no guarantee that insurers will reimburse for MYOBLOC® (rimabotulinumtoxinB) Injection.

I understand that I am under no obligation to prescribe any Solstice drug, nor will I receive any benefit from Solstice or its representatives and/or agents, for prescribing a Solstice drug. I understand that Solstice and its representatives and/or agents are not responsible for filing any insurance claims on my or my patient's behalf. I agree to abide by this declaration throughout my participation in the Program and to notify a Program representative immediately if any aspects of my certification are no longer applicable. I have read the declaration signed by my patient and understand and agree to the terms and conditions of this Program contained therein. I agree to release to Solstice information my patient has consented to be released.

Physician Name (Printed)

Physician Signature Date

FAX COMPLETED FORM TO: 1-888-343-3275