

Provider Intake Form

Spinal Cord Stimulation and The Vertiflex™ Procedure†

Boston Scientific
Advancing science for life™

To request benefit verification and pre-authorization services, complete and return form
to: fax 877-835-2520 or email PreAuthSupport@bsci.com

Complete this form once per physician

Physician Information				
Physician:		Practice Name:		
Address:				
City:	State:	Zip:	Phone:	Fax:
Contact(s):			Email:	
TID:	Billing NPI:	Doctor NPI:	BCBS:	
Medicaid:	UPIN:	ASC-DOL Prov #:	Other:	

Facility Information				
<input type="checkbox"/> 23 Hour Observation	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> ASC	
Facility:				
Address:				
City:	State:	Zip:	Fax:	
Contact(s):		Email:		
TIN:	Billing NPI:	BCBS:	Other:	

Additional Facility Information (if applicable)				
<input type="checkbox"/> 23 Hour Observation	<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Outpatient Hospital	<input type="checkbox"/> ASC	
Facility:				
Address:				
City:	State:	Zip:	Fax:	
Contact(s):		Email:		
TIN:	Billing NPI:	BCBS:	Other:	

Comments (optional)

Boston Scientific Sales Representative Information (optional if known)	
Sales Rep Name:	Phone:

†Superion® Indirect Decompression System

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