

Provider Intake Form - Men's Health

Eav. 955 961 0044

| Fax: 855-861-0044 | Email: BSC.MensHealthIntake@bsci.com | | | Questions: 855-284-1676 | | | |
|---|--------------------------------------|-------------------|-------------------------|-------------------------|-------------------------|--------|--|
| ☐ If you would like pre-autho | rization/pre-determin | ation to be proce | essed as a standard or | all applicable | cases, please check th | e box. | |
| ☐ If you would like an On-Bo the box and a BSC Prograr | | | benefits verification a | nd pre-authoriz | cation services, please | check | |
| I acknowledge, that I have | e received a copy o | of the Privacy Le | etter along with a cop | y of the Busin | ness Associate Agree | ment. | |
| Physician or Authorized Represe | | Printed Name | Date | | | | |
| | Comp | lete this form | once per physic | <u>ian</u> | | | |
| Physician Information | | | | | | | |
| Physician: Practice Name: | | | e: | | | | |
| Address: | | | | | | | |
| City: | State: | Zip: | Phone: | | Fax: | | |
| Contact(s): | | | Email: | Email: | | | |
| TID: | Billing NPI: | | Doctor NPI: | Doctor NPI: | | | |
| Medicaid: | UPIN: | | ASC-DOL Prov | ASC-DOL Prov #: | | Other: | |
| Facility Information | | | | | | | |
| 23 Hour Observation | ☐ Inpatient Hospital | | ☐ Outpatier | Outpatient Hospital | | ASC | |
| Facility: | · | | | | • | | |
| Address: | | | | | | | |
| City: | | State: | Zip: | | Fax: | | |
| Contacts(s): | | Email: | | | | | |
| TIN: | Billing NPI: | | BSC: | | Other: | | |
| Additional Facility Info | rmation (if appli | cable) | | | | | |
| 23 Hour Observation Inpatient Hospital | | pital | Outpatient Ho | ent Hospital ASC | | | |
| Facility: | • | | | | • | | |
| Address: | | | | | | | |
| City: S | | State: | Zip: | | Fax: | | |
| Contacts(s): | | | Email: | | | | |
| TIN: | Billing NPI: | | BSC: | | Other: | | |

Disclaimer: Coverage is based on patient eligibility, specific plan benefits, medical necessity, individual contracts and local coverage policies. Verification of benefits and/or prior authorization approval are not guarantees of payment. Providers must submit accurate and appropriate claims for services. It is always the provider's responsibility to determine medical necessity, the proper site for delivery of any service and to submit appropriate codes, charges and modifiers for services rendered. Boston Scientific recommends that providers consult with their payers, reimbursement specialists and/or legal counsel regarding coding, coverage and reimbursement matters.

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