PATIENT BENEFIT VERIFICATION FORM – MALE CONTINENCE

REQUEST FOR SUPPORT: ☐ BV only ☐ BV and PA/PD if applicable ☐ Appeal if applicable

Fax or Email this completed form to 855-861-0044 or BSC.MensHealthIntake@bsci.com

If requesting PA/PD or Appeal support, include patient clinical documentation supporting medical necessity

SECTION 1 Patient Information

Patient's Full Name: Patient's DOB: Procedure Date:

Address: City: State: Zip:

Phone: Employer:

Primary Insurance: ID: Group:

Secondary Insurance: ID: Group:

SECTION 2 Physician and Facility Information

Physician Name: NPI: TIN:

Facility: NPI: TIN:

Site of Surgery: ☐ ASC ☐ Outpatient Hospital ☐ Inpatient Hospital ☐ 23 Hour Observation

Office Contact Name: Phone: Email:

SECTION 3 Diagnosis and Procedure Codes

Primary ICD-10 Diagnosis Code (required): ICD-10 Procedure Code (inpatient only):

List All Secondary ICD-10 Diagnosis Code(s):

AdVance™ Male Sling System	
Code	**Description**
☐ 53440	Sling operation for correction of male urinary incontinence (eg, fascia or synthetic)
☐ 53442	Removal or revision of sling for male urinary incontinence (eg, fascia or synthetic)
AMS 800™ Urinary Control System	
☐ 53444	Insertion of tandem cuff (dual cuff)
☐ 53445	Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff
☐ 53446	Removal of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff
☐ 53447	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff at the same operative session
☐ 53448	Removal and replacement of inflatable urethral/bladder neck sphincter including pump, reservoir, and cuff through an infected field at the same operative session including irrigation and debridement of infected tissue
☐ 53449	Repair of inflatable urethral/bladder neck sphincter, including pump, reservoir, and cuff

SECTION 4 Physician Certification Section

By submitting this form to Boston Scientific, the physician identified in Section 2 of this document completed this form in its entirety (or reviewed it carefully after it was completed by an employee under their direction) and the information provided by the physician/physician's staff, including the diagnosis, codes and medical documentation supporting erectile restoration is true, accurate, and complete to the best of their knowledge. The physician also certifies that this procedure is medically necessary.

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.

Boston Scientific does not promote the use of its products outside their FDA-approved/cleared label.
Caution: US Federal Law restricts these devices to sale by or on the order of a physician.