Patient Enrollment Form

Please fax or scan/email completed form along with any supporting information to:

FAX: 1-855-630-9582

EMAIL: reimbursement@SpaceOARsupport.com

For Live Assistance Call: 1-844-284-2462

Date Submitted: ____/____/____ Time Submitted: _____:_____ AM/PM

Provider Information			
Contact Person:		Title:	
Prescribing Physician Name:		Practice Name:	
Street Address:	City:	State:	ZIP Code:
Phone Number:	Fax Number:		
Email Address:	Preferred Contact Method: ☐ Phone ☐ Fax ☐ Email		
NPI Number:	Tax ID Number:		

Patient Information (U.S. Residents Only)			
Patient's Name:	Patient's Phone Number:		Date of Birth:
Street Address:	City:	State:	ZIP Code:

Primary Insurance Information (Please Fax Copy of Insurance Card - Front & Back)		
Primary Insurance Company Name:		Insurance Phone Number:
Plan Type: ☐ HMO ☐ PPO ☐ Commercial ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other		
Member ID Number:	Group Number:	Policy Holder:
Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Secondary Insurance Information (Please Fax Copy of Insurance Card - Front & Back)		
Secondary Insurance Company Name:		Insurance Phone Number:
Plan Type: ☐ HMO ☐ PPO ☐ Commercial ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other		
Member ID Number:	Group Number:	Policy Holder:
Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		

Patient Diagnosis

Patient Diagnosis(es) (Description & ICD-10-CM):

C61 ☐ *(Note: Any other diagnosis is not eligible for this program.)*

Planned Procedure (SpaceOAR)

CPT 55874 ☐ *(Note: Any other procedure is not eligible for this program.)*

Planned Date of Service: _____

Site of SpaceOAR Procedure: ☐ Hospital Outpatient ☐ Physician Practice ☐ Ambulatory Surgery Center ☐ Other_____

Name of Facility:_____

Facility NPI Number:_____

Facility Tax ID Number:_____

Facility Contact Person:_____Phone:_____Email:_____

Type of Request

This request is for:

Benefit Verification ☐

Prior Authorization or Pre-Determination ☐

Authorization Denial Appeal Assistance ☐

Claim Denial Appeal Assistance ☐

For Authorization or Appeal assistance, please fax or scan/email supporting medical records.