Neurolutions

## Prescribing Requirements

Standard prescription and insurance forms are included on the following pages for your convenience and completion when prescribing the IpsiHand System for your patient:

Please send completed and signed **Prescription Forms** and submit completed **Insurance Forms** as well as a **copy of the front and back of insurance cards** to insurance@neurolutions.com or fax to (323) 300-2410.

## Patient Selection Criteria

**Indication for Use**

- For chronic stroke patients (≥ six months post-stroke), age 18 or older, undergoing rehabilitation to facilitate muscle re-education and for maintaining or increasing range of motion in the upper extremity.

**Contraindications**

- Severe spasticity or rigid contractures in the wrist and/or digits
- Skull defects due to craniotomy or craniectomy

**Prior Treatments & Physician Recommendation**

- An EEG Signal Test and evaluation is performed on each patient prior to dispensing.

## Neurolutions Customer Care Team

After receiving the completed documents, our team is committed to providing you and your patient the support needed throughout the entire care journey.

Beginning with reimbursement, our team will be available to you and your patients. Upon insurance approval, Neurolutions will conduct an EEG signal test. During delivery, we will provide in-depth training and will continue to support your patient as they progress through therapy.

If you or your staff have any questions about your patient's IpsiHand prescription, please do not hesitate to contact our **Customer Care team at 1-833-438-4774** or **insurance@neurolutions.com.**

We look forward to working together to provide the best possible care for your patient.

*(Please find RX and insurance forms on the following pages)*

Neurolutions

**Fill in this Insurance Template directly from your computer or print and complete by hand. Send completed and signed prescriptions to insurance@neurolutions.com or fax to (323) 300-2410**

## 1. Patient Information

FIRST NAME: _____ LAST NAME: _____

DOB: ___ /___ / ___ GENDER:_____ EMAIL:_____

ADDRESS: _____ CITY: _____ STATE: _____

PHONE:_____ CELL:_____

EMERGENCY CONTACT NAME: _____ EMERGENCY CONTACT PHONE: _____

## 2. Medical Information

ICD-10 DIAGNOSIS: _____

AFFECTED UPPER EXTREMITY: _____

PRIOR TREATMENTS ATTEMPTED:_____

## 3a. Primary Insurance Information

INSURANCE PROVIDER: _____

POLICY ID: _____ GROUP #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

BENEFITS PHONE:_____

POLICY HOLDER NAME: _____

DOB: ___ /___ / ___ RELATIONSHIP TO PATIENT:_____

Self Spouse Parent Guardian

## 3b. Secondary Insurance Information

INSURANCE PROVIDER: _____

POLICY ID: _____ GROUP #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

BENEFITS PHONE:_____

POLICY HOLDER NAME: _____

DOB: ___ /___ / ___ RELATIONSHIP TO PATIENT:_____

Self Spouse Parent Guardian

(Optional)

## 4. Primary Clinic Point of Contact

FIRST NAME: _____ LAST NAME: _____

PRACTICE NAME: _____ EMAIL:_____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP:_____ PHONE:_____ FAX:_____

**Fill in the Rx template directly from your computer or print and complete by hand**
**Send completed and signed prescriptions to rx@neurolutions.com or fax to (323) 300-2410**

IpsiHand by Neurolutions

## PATIENT INFORMATION

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____

ICD-10 CODE _____ BIRTHDATE _____ /_____ /_____
MM DD YYYY

## HEALTH CARE PRACTITIONER

FIRST NAME _____ LAST NAME _____

NPI NUMBER _____ EMAIL _____
NATIONAL PROVIDER IDENTIFIER 10-DIGIT NUMBER

ADDRESS _____ CITY _____

STATE _____ ZIP _____ PHONE _____

INSURANCE STATUS ☐ Submitted to Insurance ☐ Will Submit to Insurance ☐ N/A or will not submit

## PRESCRIPTION ITEM

**IpsiHand Upper Extremity Rehabilitation System**

LEFT OR RIGHT SIDE
☐ Left
☐ Right

DATE

_____ /_____ /_____
MM DD YYYY

_____
HCP SIGNATURE

Phone: 833-438-4774 | Fax: 323-300-2410 | 7033 Hayvenhurst Ave Van Nuys, CA 91406 | insurance@neurolutions.com