AXUMIN™
Fluciclovine F 18 Injection

Patient Benefit Verification Form

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

FAX: 1-877-309-7514

EMAIL: reimbursement@blueearthdx.com

For Live Assistance Call: 1-855-495-9200

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

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

Patient Information (U.S. Residents Only)			
Patient's Name:	Patient's Phone Number:	Gender: ☐ M ☐ F	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_____		

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Patient Diagnosis

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

Planned Procedure (AXUMIN PET/CT Scan)

CPT: ☐ 78815 ☐ 78816 ☐ 78812 ☐ 78813 ☐ A9588 ☐ Other _____

Site of AXUMIN PET/CT Scan ☐ Hospital Outpatient ☐ Independent Diagnostic Testing Facility

☐ Physician Practice ☐ Other_____

Name of Facility:_____

Facility NPI Number:	Facility Tax ID Number:	Facility PTAN # (Medicare Provider):

Facility Contact Person:_____Phone:_____Email:_____

Additional Information

Please provide any additional information that will assist with the resolution of this case:

Authorization

I verify that the patient and physician information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Axumin based on my professional independent judgment of medical necessity and it will be used as directed. I certify that I have received the appropriate permission from the patient and met any other applicable requirements imposed under the Health Insurance Portability and Accountability Act of 1996 and/or state law needed to release the above information to Blue Earth Diagnostic and its agents for the purposes of verifying the patient's insurance coverage, on my patient's behalf, and providing information on prior authorization and/or appeals for denials of claims. I authorize the Axumin Reimbursement Support Helpline Program to perform a preliminary assessment of insurance and benefit verification for the above-named patient, and I further authorize and request that the Program provide to me any and all information necessary for completing a Letter of Medical Necessity as may be required as a result of such insurance benefit verification.

Authorized Signature: _____

Title: _____

Date: _____

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Patient Authorization

I understand that I must complete this application or provide the signed consent before I can receive assistance through the Axumin Reimbursement Support Helpline Program (the "Program"). I hereby authorize my healthcare providers, pharmacies, and health plan(s) to disclose my personal health information ("PHI"), including information related to my medical condition and treatment, and all information provided on this patient enrollment form to Blue Earth Diagnostics, the manufacturer of Axumin, and to its agents and the administrator of the Program (collectively, the "Recipients"). I further authorize the Recipients to use and disclose my PHI for the purposes of establishing my eligibility for benefits from my health plan or other programs, providing appropriate educational and reimbursement support, and communicating with my healthcare providers, and for Blue Earth Diagnostics' internal business purposes, including quality control and compliance.

I understand that signing this authorization is voluntary and that if I were to refuse to sign, that would not affect my eligibility for health plan benefits or ability to obtain treatment by my healthcare providers. I also understand, however, that if I refuse to sign, I will not have access to the services offered by the Program. I also understand that if I sign this authorization, I can cancel it at any time by notifying Blue Earth Diagnostics in writing at reimbursement@blueearthdx.com. Upon receiving my notice of cancellation, Blue Earth Diagnostics would stop using this authorization to access, use, or disclose my PHI, but the cancellation would not apply to any PHI that had already been used or disclosed pursuant to this authorization. I understand that information that I authorize to be disclosed hereunder may be re-disclosed and no longer protected by certain federal or state privacy laws.

This authorization will expire two (2) years after the date it is signed below. I have read this authorization or have had it explained to me. I understand that I will receive a copy of this authorization after I sign it.

Patient Signature: _____

Date: _____