**CardioMEMS™ PA Sensor Case Information Form**

This form provides information to Abbott for the purpose of facilitating patient access to Abbott’s CardioMEMS™ HF System for the patient identified below and, specifically, for the purpose of facilitating Abbott’s submission of a preauthorization request specific to such patient’s care, as recommended by the patient’s physician.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION | | | | | | | | |
| Patient Name | | | | | | Date of Birth | | Phone |
| Address/City/State/Zip | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | |
| Primary Insurance | | |  | | | Member ID | | Group ID |
| Subscriber Name | | | Type of Plan (HMO/PPO/Other) | | | Insurance Phone Number | | |
| Does provider participate with network?  YES | NO | | | Do you have a referral on file?  YES | NO | | | Subscriber’s Date of Birth | | |
| Secondary Insurance | | |  | | | Member ID | | Group ID |
| Subscriber Name | | | Type of Plan (HMO/PPO/Other) | | | Insurance Phone Number | | |
| Does provider participate with network?  YES | NO | | | Do you have a referral on file?  YES | NO | | | Subscriber’s Date of Birth | | |
| **IMPLANTING PHYSICIAN INFORMATION** | | | | | | | | |
| Physician Name | | | | | | Phone | | NPI |
| Address/City/State/Zip | | | | | | Fax | | TIN |
| Practice Name | | | | | | Office Contact | | |
| Phone Number | | |
| **FACILITY INFORMATION** | | | | | | | | |
| Name of facility where procedure will be performed | | | | | | Phone | | NPI |
| Address/City/State/Zip | | | | | | Fax | | TIN |
| PROCEDURE | | | | | | | | |
| Procedure Date | | Procedure Code(s) | | | ICD-10 Diagnosis Codes(s) | | | |
| Place of Service | | Equipment Code(s) | | |
| PRIOR TREATMENT FOR DIAGNOSIS (please include clinical records) | | | | | | | | |
| Previous therapies & medications (list all) | | | | | | | | |
| OTHER PERTINENT INFORMATION (circle answer, include diagnostic test results and clinical documentation) | | | | | | | | |
| Patient history & YES | NO physical included: | Medical records indicate a Heart  Failure (HF) hospitalization within YES | NO  the previous year: | | | Date of last Heart Failure (HF) hospitalization: | | | NYHA Class of Heart Failure: | |
| (Physician Initials) The planned procedure for this patient is indicated for wirelessly measuring and monitoring pulmonary artery (PA) pressure and heart rate in New York Heart Association (NYHA) Class III heart failure patients who have been hospitalized for heart failure in the previous year; the hemodynamic data are used by physicians for heart failure management and with the goal of reducing heart failure hospitalizations.  By signing this form, I hereby certify I am authorizing Patient Therapy Access (PTA) to review and submit this case information to a patient’s health insurer for the purpose of seeking pre-authorization or pre-qualification for coverage of a procedure involving an Abbott device. In the event that the original request is rejected, I authorize PTA to appeal the case as applicable and will provide additional information as requested by PTA to support this action. I authorize PTA to provide case-related updates to the Abbott field team that supports my clinic(s).  I further certify that I have received the necessary authorization(s) to release the above-referenced information and other protected health information (as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996) to PTA for the purpose of seeking pre-authorization, pre-qualification, and / or appeal for coverage of a procedure involving an Abbott device. I certify that the above-referenced patient has provided my office with written consent and authorization to proceed utilizing PTA for  the purposes referenced above. I understand that if I have not secured consent from my patient, PTA will be unable to proceed with this request. I confirm I have the patient’s consent prior to this authorization. I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. | | | | | | | | |
| Physician Signature | | | | | Date Signed: | | | |

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**Instructions for Use:**

* Complete page 1 in its entirety
* Physician Signature and Date is required on page 1
* Return completed document to [ptherapyaccess@abbott.com](mailto:ptherapyaccess@abbott.com) or fax to 877-716-7246

**2019 ABBOTT** | CardioMEMS™ PA Sensor Case Information Form

# PLEASE SEND THE FOLLOWING DOCUMENTS WITH THE CASE INFORMATION FORM TO THE PATIENT THERAPY ACCESS (PTA) DEPARTMENT:

Fax: 877-716-7246 or Email: [ptherapyaccess@abbott.com](mailto:ptherapyaccess@abbott.com)

# MEDICARE

1. Case information form
2. Signed patient release of records
3. Copy of the Medicare card and any secondary or supplemental policies
4. Must be a Medicare-approved diagnosis as listed in the Medicare policy
5. Clinical information
   * Letter of medical necessity
   * Current office visit notes
   * History and physical
   * Previous treatment notes
   * Diagnostic test reports

# PRIVATE INSURANCE

1. Case information form
2. Signed patient release of records
3. Copy of the insurance cards with phone numbers and claim address
4. Clinical information
   * Letter of medical necessity
   * Current office visit notes
   * History and physical
   * Previous treatment notes
   * Diagnostic test reports

Please contact the Abbott PTA Department with any questions at 877-706-7246 or your dedicated PTA Case Manager.

# Disclaimer

This document and the information contained herein is for general information purposes only and is not intended and does not constitute legal, reimbursement, coding, business or other advice. Furthermore, it is not intended to increase or maximize payment by any payer. Nothing in this document should be construed as a guarantee by Abbott regarding levels of reimbursement, payment or charge, or that reimbursement or other payment will be received. Similarly, nothing in this document should be viewed as instructions for selecting any [particular code. The ultimate](https://rsdguide.com/crps-rsd/) responsibility for coding and obtaining payment/reimbursement remains with the treating physician. This includes the responsibility for accuracy and veracity of all coding and claims submitted to third-party payers. In addition, the treating physician should note that laws, regulations, coverage and coding policies are complex and updated frequently. Therefore, the customer should check with their local carriers or intermediaries often and

should consult with legal counsel or a financial, coding or reimbursement specialist for any coding, reimbursement or billing questions or related issues.

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**Abbott**

6901 Preston Road., Plano, TX 75024, USA

**Rx Only**

**Brief Summary:** Prior to using these devices, please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions, potential adverse events and directions for use.

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Item approved for U.S. only.

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