FlexForward® iovera° Enrollment Form

Fax completed enrollment form to 1-866-558-7939

Call us at 1-844-353-9466, Monday - Friday, 8 AM - 8 PM ET

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Note: Fields marked with * are required.

1A. Patient Information

Last name*: _____ First name*: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Cell phone #: _____ Home phone #: _____ Email: _____

Gender*: ☐ Male ☐ Female Date of birth*: ____/____/____

1B. Insurance Information

Attach a copy of both sides of the patient's insurance card(s) and/or fill out the insurance information below.

Is the patient enrolled in a government-funded healthcare program such as Medicare, Medicaid, VA, DoD, TRICARE, a qualified health plan (QHP), or a plan offered under a state or federal exchange?* ☐ Yes ☐ No

Primary Insurance

Plan name*: _____

ID #*: _____ Group #: _____

Plan phone #*: _____

Policy holder: _____

Date of birth of policy holder (if different from patient): ____/____/____

Relationship to patient: _____

Secondary Insurance

Plan name: _____

ID #: _____ Group #: _____

Plan phone #: _____

Policy holder: _____

Date of birth of policy holder (if different from patient): ____/____/____

Relationship to patient: _____

2A. Treating Provider Information

Treating provider name and Credentials (if known): _____

NPI #*: _____ State license #: _____ Tax ID #: _____ DEA #: _____

Office/Group Name*: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Phone #*: _____ Fax #*: _____

Primary Contact: Preferred method of contact: ☐ Phone ☐ FlexForward Portal

Contact name: _____ Email: _____ Phone #: _____

2B. Treating Facility Information

Treating facility name: _____ Facility NPI: _____

Address*: _____ Phone #: _____

Place/Site of service: ☐ 11-Physician office/clinic ☐ 24-Ambulatory Surgery Center
☐ 19-Hospital Outpatient Department (Off-campus) ☐ 22-Hospital Outpatient Department (On-campus)

2C. Referring Provider Information

Last name*: _____ First name*: _____ Credentials: _____

Office name: _____

Address*: _____ City*: _____ State*: _____ ZIP*: _____

Phone #*: _____ Fax #*: _____

3. Diagnosis and Clinical Information

iovera° Treatment date: _____ Last surgical date: _____ Scheduled surgical date: _____

ICD-10 Code* Pain ICD-10 code: _____ Additional ICD-10 code: _____

CPT code (select all nerves being treated*): ☐ 64640 - Peripheral nerve or branch ☐ 64624 - Superolateral, superomedial, and inferomedial
☐ 64620 - Intercostal nerve ☐ 76942 - Ultrasound Guidance, with permanent recording and reporting

Treatment area*: ☐ Left knee ☐ Right knee ☐ Bilateral knees ☐ Other _____

Quantity of nerves intended for treatment (up to 5 nerves): _____

4. iovera° Indication for Use

The iovera° system is used to destroy tissue during surgical procedures by applying freezing cold. It can also be used to produce lesions in peripheral nervous tissue by the application of cold to the selected site for the blocking of pain. It is also indicated for the relief of pain and symptoms associated with osteoarthritis of the knee for up to 90 days. The iovera° system is not indicated for treatment of central nervous system tissue.

When stimulation compatible components are used, the iovera° system can also facilitate target nerve location by conducting electrical nerve stimulation from a compatible third-party nerve stimulator.

5. Physician Authorization

By signing below, I certify that (1) the above therapy is medically necessary and in the best interest of the patient listed above; (2) the information provided is complete and accurate to the best of my knowledge; (3) I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pacira BioSciences and its contractors and business partners ("Contractors") for purposes relating to the FlexForward program, to solely assist with benefits verification, prior authorization/appeals assistance; and (4) I agree to the Business Associate Agreement as presented at https://baa.flexforward.com/.

Treating provider name (please print)*: _____ Credentials*: _____

Treating provider signature*: _____ Date*: ____/____/____

For more information, please see www.ioverapro.com.

iovera°®

PP-IO-US-1164 02/25

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