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

Fax the completed enrollment form to us at 1-866-558-7939

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 (*if known*): _____

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

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 ☐ **64635** - Single facet joint
☐ **64636** - Each additional facet joint ☐ **64999** - Unspecified code (*may also be considered when billing for Medial Branch Nerves*)
☐ **0440T** - Cryoablation upper ext.† ☐ **0441T** - Cryoablation lower ext.† ☐ **0442T** - Cryoablation nerve plexus or other†

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

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

4. 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://flexforward.com/pages/baa.

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

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

For more information, please see ioverapro.com.

†May be recommended by some Medicare Administrative Contractors (MAC)

View Instructions for Use at ioverapro.com/IFU

iovera°®

© 2025 Pacira BioSciences, Inc. All rights reserved. iovera° is a trademark of Pacira CryoTech, Inc., and FlexForward is a trademark of Pacira Therapeutics, Inc., wholly owned subsidiaries of Pacira BioSciences, Inc.
PP-IO-US-1462 09/25

FlexForward® Comprehensive Access Support | pacira BIOSCIENCES