NeuroMend INFUSION CENTER

Date: _____

Patient Name_____ **DOB**_____

Phone_____ **Email** _____

☐ **M** ☐ **F** **Weight** _____ **Height** _____

REFERRING PROVIDER:

Provider: _____ NPI: _____

Phone: _____ Fax: _____

DIAGNOSIS: (Patients with schizophrenia and/ or a current manic episode are not eligible for treatment)

Please provide icd-10 code and date diagnosed

Treatment Resistant Depression: _____ Date of Diagnosis: _____

Other Diagnosis: _____ Date of Diagnosis: _____

PRIOR FAILED DERESSION THERAPIES (MEDICATIONS): **Must have at least 2 failed therapies

1. Medication: _____ Highest dose: _____ Trial dates: _____
2. Medication: _____ Highest dose: _____ Trial dates: _____
3. Medication: _____ Highest dose: _____ Trial dates: _____
4. Medication: _____ Highest dose: _____ Trial dates: _____

Insurance Information:

Insurance:_____ Member ID:_____ Group No.:_____

Policy holder's name (if different from patient) _____

** Please include copies of demographics (photo ID and insurance cards) and recent clinic notes which explain the patients past psychiatric treatment. This is necessary for us to move forward with insurance authorizations and benefits.

Additional Notes: _____

_____

_____

Signature: _____ Date: _____

Please fax completed form to: (337)347-6498 Attn: Spravato

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Phone: (337) 347-6655 Email: administration@neuromendcenter.com