intandem™

Fax completed & signed forms to:
(844) 440-9300

Need help enrolling a patient?
intandemrx.com or
call 1 (844) 400-9255

Patient Enrollment Form

Patient Information

Read the InTandem Program Certifications & Authorizations then check/sign below: **www.intandemrx.com/terms**

First Name		Last Name			
Date of Birth	MM / DD / YYYY	Phone #			
Address					
City		State		Zip	
Email Address					

☐ **I authorize the sharing of my health information with InTandem Support and consent to be contacted by phone call, voicemail, text message, and/or email.***

Patient/Legal Rep Signature*			
Patient/Legal Rep Written Name*		**Date**	MM / DD / YYYY

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.

Order Information

☐ **Use for 2 months, 3 sessions per week**

OR

Duration of Use Rental months	☐ 1	☐ 2	☐ 3	☐ 4	☐ 6	☐ ___
Frequency of Use Sessions per week	☐ 3	☐ 4	☐ 5	☐ 6		☐ ___

Clinical Rationale for Patient	☐ ICD-10 I63.________ ☐ ICD-10 I69.________ ☐ ICD-10 ________	Additional Clinical Rationale	☐ History of stroke ☐ Gait impairment due to stroke ☐ ________

Prescriber Authorization

First Name		Last Name			
NPI		HCP License			
Practice Name		Address			
City		State		Zip	
Practice Phone #		Practice Fax #			
Practice Email					

This document serves as a Standard Written Order and Prescription for InTandem [UDI: (01)00860001790801] for this patient. As this patient's physician, I attest that the clinical findings on this document accurately reflect the health information. I certify that InTandem is reasonable and medically necessary for the treatment of this patient.

Physician Signature		**Date**	MM / DD / YYYY

Health Insurance Information

HCPs: Complete form below or include a summary report from your EHR with the Patient Enrollment Form (page 1).

Patients: InTandem Support works with your insurance company to determine your costs before you commit. To provide your insurance information call InTandem Support at: 1 (844) 400-9255

Patient Information					
First Name		Last Name			
Patient Insurance Information	Status	☐ Insured	☐ Uninsured	☐ Unknown	
Insurance Provider		Plan Phone #			
Member ID		Group #			
Policy Holder Name					
Policy Holder Relationship to Patient	☐ Self	☐ Spouse	☐ Parent / Guardian		

Secondary Insurance Information (optional)				
Insurance Provider		Plan Phone #		
Member ID		Group #		
Policy Holder Name				
Policy Holder Relationship to Patient	☐ Self	☐ Spouse	☐ Parent / Guardian	

To add additional insurance plans, contact InTandem Support: 1 (800) 400-9255

Add an Additional Contact

Optional

Provide contact information and consent for InTandem Support to contact a representative on your behalf. This person will receive all program correspondence.

Patient Information			
First Name		Last Name	

☐ I authorize InTandem Support to contact and correspond with the person named below

First Name		Last Name		
Relationship				
Email Address				
Phone Number		☐ Smartphone	☐ Cell Phone	☐ Landline
Preferred Contact Method	☐ Phone call	☐ Text Message	☐ Email	
Signature of Patient or Legal Representative*		Today's Date MM/DD/YYYY		
Print Name of Patient or Legal Representative*		Relationship to Patient (*optional*)		

*By signing on behalf of the patient, as representative or guardian, I attest that I am legally able to sign such documents on the patient's behalf and am properly acting in my capacity in doing so. Proof of such guardian's or representative's authority to act for the patient may be requested such as power of attorney or legal court order.