TESTOPEL® 75mg (testosterone pellets) ℞

TESTOPEL® Reimbursement Program

Enrollment Form

Program Services Requested

Pre-Treatment

Please select from the following:

☐ **Benefit/Coverage Verification:** Check your patient's plan for coverage of **TESTOPEL®** pellets. Please note this is not a guarantee of payment or payment rate.

☐ **Prior Authorization Assistance:** Research PA requirements for your patient's plan, gather needed paperwork, submit and follow up with insurance.

Physician Information

Name: Barry M. Rodwick, M. D.

Specialty: Internal medicine

State License: ME0056513

NPI: 1720084445

Street Address: 3135 State Road 580, suite 1

City: Safety Harbor

State: Florida Zip: 34695

Phone: Fax: (727) 725-8826

Email: Doc@DrRodwick.com

Patient Information

Name

DOB

Street Address

City

State Zip

Phone Alt Phone

Email

Insurance Information

Insurance Company

Subscriber Name

Policy Number

Group Number

Phone

Relationship to Subscriber ☐ Self ☐ Spouse ☐ Other

Is Provider Contracted With This Insurance? ☐ Yes ☐ No

Post Treatment

Please select from the following:

☐ **Claim Denial:** Research appeals requirement for your patient's plan, draft and submit appeal letter until all options are exhausted.

☐ **Claim – Low Payment:** Review reason for low payment and follow up with insurance for resolution.

Physician Certification and Request

I verify that the patient and prescriber information contained in this form is complete and accurate to the best of my knowledge and that I have prescribed **TESTOPEL®** based on my professional judgment of medical necessity. I authorize Slate or its affiliated companies, agents or subcontractors to perform any steps necessary to obtain reimbursement for **TESTOPEL®** including but not limited to insurance verification and case assessment. I understand that Slate or its affiliated companies, agents or subcontractors may need additional information, and I agree to provide it as needed for the purposes of reimbursement.

Physician's Full Signature

Date

Patient Certification and Request

In order for me to obtain services under the **TESTOPEL®** Reimbursement Program, I understand that Slate, its affiliates and authorized agents administering the program (including third-party administrators) will need to review, use and disclose information about me, my health insurance coverage, and my medical diagnosis and treatment (including my use or need for Slate's product, **TESTOPEL®**). I request and authorize my doctor and other healthcare professionals ("Doctor(s)") and my health plan or insurance company ("Insurer(s)") to give Slate, its affiliates and authorized agents administering the program (including third-party administrators) information about me, my health insurance coverage, and my medical diagnosis and treatment (including my use or need for Slate's product, **TESTOPEL®**). This information can include spoken or written facts about my health and payment benefits, as well as copies of records from Doctor(s) or Insurer(s) about my health or healthcare.

Patient's Full Signature

Date

☐ Patient has verbally certified the above statement.

Authorized Office Signature

Barry M. Rodwick, M. D.

Authorized Office Full Name

M. D.

Title

Date

Confidential Information: If you have received this information in error, please call 866.752.8350, opt. 5.

Fax completed form to: (f) 866.935.1355