

# MOVIVE Patient Enrollment Form

Movive Support: (855) 600-1234  
Fax: (855) 515-1500  
Secure Upload: [movive.com/upload](http://movive.com/upload)

# MOVIVE™

By MedRhythms  
[www.movive.com](http://www.movive.com)

1. Complete all required fields in this form.
2. Send completed forms by fax to (855) 515-1500 or via secure upload at [movive.com/upload](http://movive.com/upload)
3. **To expedite, please include copies of 1) patient's clinical notes, 2) face sheet, and 3) patient's insurance card.**  
Failure to do so will result in prescription processing delays.

## Patient Authorization

*For the patient to complete.*

By signing below, I authorize the sharing of my health information with Movive Support and consent to be contacted by phone call, voicemail, text message, and/or email, directly or through the person listed under "Primary Contact". I also confirm that I have read the Program Certifications & Authorizations (see [www.movive.com/terms](http://www.movive.com/terms) or following pages).

Patient or Legal Representative\* Signature \_\_\_\_\_

Patient Printed Name \_\_\_\_\_ Date (MM/DD/YYYY) \_\_\_\_\_

## Primary Contact

*For the patient, legal representative, or prescriber to complete.*

Please provide contact information for the patient or the best authorized person to speak with regarding all patient and prescription details. Call Movive Support (855-600-1234) or go to [movive.com/enroll-contactinfo](http://movive.com/enroll-contactinfo) to add additional contacts or methods of contact.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ ☐ Patient ☐ Spouse ☐ Other: \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Type: ☐ Cell ☐ Home ☐ Work

Email \_\_\_\_\_ Communication Preference: ☐ Mail ☐ Email ☐ Phone

## Order Information

*For the prescriber to complete.*

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_ Patient DOB \_\_\_\_\_

### Length of Need for MOVIVE (HCPCS-code E3200)

#### Duration

☐ 3 Months

☐ 6 Months

☐ 99 Months (Lifetime)

☐ Other Duration \_\_\_\_\_

#### Recommended Frequency

☐ 3x/week (Recommended)

☐ 2x/week

☐ Other Frequency \_\_\_\_\_

### Diagnosis Code (ICD-10)

#### Parkinson Codes

☐ G20.A1 ☐ G20.B1

☐ G20.A2 ☐ G20.B2

☐ \_\_\_\_\_

#### Gait Impairment Codes

☐ R26.89 ☐ Z74.09

☐ R26.81 ☐ R26.9

☐ \_\_\_\_\_

## Prescriber Authorization

*For the prescriber to complete.*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ NPI # \_\_\_\_\_

Practice Name \_\_\_\_\_ HCP License \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Email \_\_\_\_\_

This document serves as a Standard Written Order and Prescription for Movive [UDI: 00860001790818] 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 Movive is reasonable and medically necessary for the treatment of this patient.

### If patient has not signed above:

- ☐ By checking at left, I confirm that I have the patient's written consent to release to MedRhythms and its representatives, agents, and contractors his or her protected health information ("PHI"), including but not limited to my patient's name, medical records, information relating to his or her medical condition, treatment, and health insurance, as well as all information provided on my prescription for purposes of providing the services offered by Movive support, including without limitation, financial support services, providing product support, communication and exchange PHI with my patient's health care providers, pharmacies or medical equipment suppliers, and health insurers for reasons related to the program, and contacting my patient by mail, email, text, or telephone (including voicemail).

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

\*By signing on behalf of the patient, as representative or guardian, you attest that you are legally able to sign such documents on the patient's behalf and are properly acting in your capacity 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.

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