MOVIVE Patient Enrollment Form

MOVIVE Support: (855) 600-1234
Fax: 636-565-1111
Secure Upload: movive.com/upload

MOVIVE®
By MedRhythms
www.movive.com

1. Complete all required fields in this form.
2. Send completed forms by fax to 636-565-1111 or via secure upload at 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 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 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)

☐ 3 Months ☐ 99 Months (Lifetime)
☐ 6 Months ☐ Other Duration _____

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
☐ _____

Comments _____

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.