

Monarch Pediatric Care Program Enrollment Form

The information you provide will be used by NeuroSigma, its affiliates, and service providers for your patient's enrollment and participation into the Monarch Pediatric Care Program. You may withdraw by calling 877-765-7660.

Please fax completed form back to 703-832-8447.

PATIENT INFORMATION

Patient First Name _____ Patient Last Name _____
 Date of Birth _____ Parent / Caregiver Name and Relationship _____
 Parent / Caregiver Phone _____ Alternate Phone _____
 Address _____ City _____ State _____ Zip _____
 Parent / Caregiver Email _____

INSURANCE INFORMATION

Primary Insurance Name _____ Phone _____
 Cardholder Name _____ Policy # _____ Group # _____
 Prescription Plan Name _____ Phone _____
 Policy # _____ Group # _____
 BIN # _____ PCN # _____

PRESCRIBER INFORMATION

HCP Name _____
 Site Name _____ Site Contact _____
 Address _____ City _____ State _____ Zip _____
 Email _____ Phone _____ Fax _____
 NPI _____ Tax ID _____ State License _____

PRESCRIPTION INFORMATION

Monarch eTNS Starter Kit (Monarch eTNS System and 4-week supply of disposable patches) QTY = _____
 Disposable electric patches (dispensed in packages of 7 – 1 week supply) QTY = _____

DISPENSE AS WRITTEN – there is no suitable alternative for the Monarch Electric Patches

I certify that the above device is medically necessary, and that the information provided is accurate to the best of my knowledge. By my signature, I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by the Monarch Pediatric Care Program to provide the offerings selected. I appoint the Monarch Pediatric Care Program, on my behalf, to convey this prescription to the dispensing pharmacy or durable medical equipment distributor of the patient's choice. I further certify that (a) any offering provided through this program on behalf of any patients not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use the Monarch Pediatric Care Program or any other product or service for anyone, and that (b) my decision to prescribe the products set forth on this page and request NeuroSigma Navigator Service offerings for my patient was based solely on my determination of medical necessity as set for herein, and that (c) I will not seek reimbursement for any offering provided by or through this service from any government program or third-party insurer.

[Signature] Prescriber Signature _____ Date _____

Please include copies of clinical documentation as necessary

CLINICAL INFORMATION

Diagnosis F90 F90.1 F90.2 F90.8 F90.9 Other ICD-10 Code _____
 Current/Most recent ADHD Therapy _____ MM/YY _____ to _____
 Other ADHD Therapy _____ MM/YY _____ to _____
 Please list any known allergies _____

AUTHORIZATION TO DISCLOSE AND USE MEDICAL INFORMATION

This Authorization allows my healthcare providers and my durable medical equipment or pharmaceutical suppliers (together, "healthcare providers") and health plans to disclose to NeuroSigma, Inc. and its third-party contractors, agents, and assignees (together, "NeuroSigma") protected health information ("PHI") about me related to my use or need for the products covered by the Monarch Pediatric Care Program. My PHI will include spoken or written facts, copies of my medical or other records from my healthcare providers, health plan or other sources outlining my medical history, treatment/management plan and other social determinants of health, as well as my insurance benefits and coverage information. The purpose of the disclosure and use set out above is to allow NeuroSigma to verify and/or obtain insurance coverage for the NeuroSigma products specified and to advise NeuroSigma with regards to the best form of communication to meet my needs. I understand that: (1) Once my PHI has been disclosed to NeuroSigma it may no longer be protected by federal privacy law and may be re-disclosed by NeuroSigma as a result. (2) I can refuse to sign this Authorization without impacting the start, continuation, or quality of my treatment, payment for treatment, clinic or insurance enrollment, or eligibility for insurance benefits or coverage because my healthcare provider and/or health plan cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization, but I will not be able to receive services from the Monarch Pediatric Care Program. (3) I may revoke, cancel or withdraw this Authorization at any time and for any reason by sending a signed written letter to the Monarch Pediatric Care Program at the following address: 45610 Woodland Road, Suite 320, Sterling, VA 20166. (4) If I cancel this Authorization, such cancellation will not change any actions that NeuroSigma or others took in reliance upon this Authorization before the date that I cancelled this Authorization. (5) This Authorization expires when my consideration for or participation in the Monarch Pediatric Care Program ends. (6) I have the right to receive a copy of this form from NeuroSigma. I give my permission to allow NeuroSigma to provide me with information about NeuroSigma products, disease education and awareness management programs, and promotional materials related to my condition or treatment.

Parent Signature (or Patient's Representative) _____ Date _____