PROPEP®
SURGICAL
512-617-6740 | www.ProPepSurgical.com

EMAIL OR FAX ORDER FORM TO:
Email:patientcare@propepsurgical.com
Fax: 512-379-5276

Order Form for Pep Electrode® Kit

Section 1: Patient Information

Patient Name: Date of Birth:

Mailing Address: Email:

Preferred Phone: Mobile Phone:

Insurance Type:
☐ Commercial Insurance
☐ No Insurance (Cash)
☐ Medicare
☐ Medicaid
☐ Other:

SUBMIT COMPLETED FORMS TO ProPep Surgical®
Fax: 512-379-5276 Email: patientcare@propepsurgical.com
PLEASE NOTE DATE OF SURGERY BELOW
ProPep Surgical | 11614 Bee Cave Road, Suite 220 | Austin, Texas | 512-617-6740

Section 2: Order Approval and Process

You are authorizing this office to order a Pep Electrode® Kit to be used during your procedure.

Procedures and Services	Product Number	Estimated Cost	Qty
Pep Electrode® Kit	RLSP370	$750.00	1

Ordering Surgeon Name: **Date of Surgery:**

Office Address: Office Phone:

Office Contact Name: Office Email:

Physician Signature:

Ship To Hospital: Company: Contact Name:

Ship To Address: Ship To Phone:

Ship To Email:

How to Process Order:
Step 1: Complete and sign this form
Step 2: Fax or email this completed form and HIPPA Authorization to ProPep Surgical®
Email: patientcare@propepsurgical.com Fax: 512-379-5276

Order Details for Patient:

- Order Confirmation: Once order is submitted a ProPep Surgical® representative will call the patient (at the number provided) within 24 hours of receipt of the order. The call will come from area code 512 (Central Texas).
- Delivery: ProPep Surgical® will ship order to the location of the procedure.

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Section 3: Advance Beneficiary Notice of Noncoverage (ABN)

Your insurance does not allow for everything, even some care that you or your health care provider has good reason to think you need. We expect insurance may not pay for the procedures or services below:

Procedures and Services	Reason Medicare May Not Pay	Estimated Cost
ProPep Pep Electrode Kit	Considered not medically necessary for robotic prostate surgery	$750.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedures/services listed above.

OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1: I want the procedures/services listed above. I am responsible for payment for the Pep Electrode kit prior to procedure. I will also be responsible for filing my insurance for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I can appeal to my insurance by following the directions on the EOB. If my insurance does pay, payments will be made directly to me from the insurer, less co-pays or deductibles.

☐ OPTION 2: I don't want the procedures/services listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance would pay.

This notice gives our opinion, not an official decision by your insurance. If you have other questions regarding your coverage, please contact your insurance carrier directly.

Signing below means that you have received and understand this notice:

Patient Signature: **Date:**

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Section 4: HIPAA Authorization Form for the Disclosure of Patient Protected Health Information

To the Patient: Please complete this Authorization, sign and date it, and return it to ProPep Surgical®. You are entitled to a copy for your records. ProPep Surgical® will retain the signed Authorization with the patient's records.

Patient Information:

First Name: _____ Last Name: _____

Date of Birth: _____

I request and authorize ProPep LLC. (Collectively "ProPep") to use and share Protected Health Information (my "Information") with its affiliates, contractors, agents and service providers who work on behalf of ProPep. My Information may include my name and birth date, my address and telephone number, my email address, my Social Security number, financial information about me, information about my health benefits or health insurance coverage, information on my medical condition, information identifying my current health providers, medical order-related health records, information about my health care plan benefits, demographic, contact, and any other information bearing on my health. My Information may be used to provide me with the education, information, support, and other services provided by ProPep such as registering my product and periodic outreach calls and surveys. In addition, my Information may be used to verify treatment and payment decisions with my health care providers; investigate and assist with coordination of coverage for ProPep products; coordinate medical order fulfillment and financial assistance; perform internal analysis at ProPep to better meet patient needs; determine my eligibility for support services; to evaluate patient satisfaction; for marketing purposes; and for use in research and related publications. I understand that once I give ProPep my Information based on this Authorization, federal privacy laws, such as HIPAA, may not prevent ProPep from further disclosing my information to other entities.

I know that I can revoke this Authorization at any time by writing to ProPep at: 11614 Bee Cave Rd., Suite 220, Austin, TX. 78738. If I revoke this Authorization, then ProPep will stop providing my Information to its representatives. However, I understand that any such revocation will not apply to any of my Information already used or disclosed based on this Authorization prior to ProPep's receipt of the revocation.

I understand that I can refuse to sign this Authorization and that this will not affect my treatment or payment for treatment, enrollment, insurance coverage, or eligibility for benefits. This Authorization will expire one (1) year after the date it is signed below, unless a shorter time period is required by state law.

Patient or Legally Authorized Representative of Patient (Authority to sign on behalf of Patient [if applicable])

Which best describes you? ☐ **I am a patient** ☐ **I am a legally authorized representative**

Name (please print) _____

Signature _____ Date: _____