RelieVRx

Customer Support: 1 (844) 728-4487
Fax Completed Forms: 1 (877) 552-1753
www.RelieVRx.com

1. Complete all required fields in this form.
2. Confirm coverage criteria and medical necessity documentation requirements are met/filled out.
3. Fax this form and provide the patient's most recent visit notes and medical necessity documentation to: 1 (877) 552-1753.

Patient Information

*Indicates required field

***Patient First Name** _____ Middle Name _____ ***Patient Last Name** _____

***Patient Date of Birth (MM/DD/YYYY)** _____ ***Gender:** ☐ **Female** ☐ **Male** ☐ **Non-binary**

***Street Address** _____

***City** _____ ***State** _____ ***Zip Code** _____

***Phone Number** _____ ***Type:** ☐ **Cell** ☐ **Home** ☐ **Work**

***Email** _____ Communication Preference: ☐ Phone ☐ Email

***Emergency Contact** _____

***Emergency Contact Phone Number** _____ ***Emergency Contact Relationship** _____

Patient Insurance

*Indicates required field ☐ ***Patient Uninsured**

To expedite, please provide a copy of the front and back of the patient's insurance card.

*PRIMARY INSURANCE

***Primary Medical Insurance** _____

***Insurance Telephone Number** _____

***Subscriber ID** _____ Group ID _____

Policy Holder Name _____

Policy Holder Date Of Birth _____

Relationship _____

SECONDARY INSURANCE

Secondary Medical Insurance _____

Insurance Telephone Number _____

Subscriber ID _____ Group ID _____

Policy Holder Name _____

Policy Holder Date Of Birth _____

Relationship _____

Prescriber information

*Indicates required field

***Prescriber First Name** _____ ***Prescriber Last Name** _____

***Location Address** _____

***City** _____ ***State** _____ ***Zip Code** _____

***Phone Number** _____ ***Fax Number** _____ ***Prescriber NPI#** _____

***Office/Practice Name** _____ ***Practice Contact** _____

***Prescriber Email** _____

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Workers' Compensation Information (If applicable)

This section is only required if you are submitting on behalf of a Workers' Compensation claim.

Claims Administrator Information _____

Claim Number _____

Employer Name _____

Date Of Injury _____ Claims Administrator Phone Number _____

Claims Administrator Email _____

Prescription & Clinical Information

*Indicates required field

***Diagnosis Code:** (Select All That Apply)

- ☐ **M54.50** (Low Back Pain, Unspecified)
- ☐ **M54.51** (Vertebrogenic Low Back Pain)
- ☐ **M54.59** (Other Low Back Pain)
- ☐ _____ Other

Notes: _____

Indication for Use

RelieVRx® is a prescription-use immersive virtual reality system intended to provide adjunctive treatment based on cognitive behavioral therapy skills and other evidence-based behavioral methods for patients (age 18 and older) with a diagnosis of chronic lower back-pain (defined as moderate to severe pain lasting longer than three months). The device is intended for in-home use for the reduction of pain and pain interference associated with chronic lower back pain.

Prescribing Information

Length Of Need: **3 Months**

Frequency Of Use:
1 Session Daily

Item To Dispense: **RelieVRx Dispense: One VR Device. Dispense As Written.**

Prescriber Authorization

I certify that I am the prescribing provider identified above and have reviewed all of the order information above. Any statement attached hereto, has been reviewed and signed by me. I certify that all the medical necessity information is true, accurate, and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of RelieVRx. I understand the indications for use and associated warnings and precautions of the RelieVRx product I have prescribed herein. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

***Prescriber Signature** _____ ***Date** _____