PATIENT APPLICATION

For the VNS Therapy™ System

Please fax completed application to VNS Therapy Access Program at (888) 577-7205

SECTION 1 PATIENT DATA

Patient Name: _____ Phone Number: _____

Address: _____

City: _____ State:_____ Zip:_____

Patient's Diagnosis: _____ Date of Birth:_____

Pertinent Clinical Information: (may attach clinical notes)

_____

_____

_____

_____

_____

_____

Referring MD: _____

Phone Number: _____ Fax: _____

Address:_____ City:_____State: _____Zip: _____

Contact Name: _____ Phone Number: _____

SECTION 2 PATIENT FINANCIAL STATUS

❑ Yes ❑ No Does patient have insurance?

❑ Yes ❑ No Does patient have ability to obtain insurance?

❑ Yes ❑ No Does patient have Medicaid?

❑ Yes ❑ No Does patient have ability to pay?

I have reviewed this program with my doctor and understand the guidelines.

Patient's Name: _____ Date: _____

Patient or Guardian Signature: _____

SECTION 3 PHYSICIAN REQUEST

I request for Cyberonics to qualify this patient to participate in the VNS Therapy Access Program that entitles him/her to a VNS Therapy System. Cyberonics will provide the VNS Therapy System only. I understand that VNS Therapy Systems will be provided on a first come first served basis.

❑ Surgeon has been contacted and agrees to provide services free of charge.

Surgeon Name: _____Contact: _____Phone: _____

❑ Hospital has been contacted and agrees to provide services free of charge.

Name: _____Contact: _____Phone: _____

Physician's Name (Print): _____ Date: _____

Physician's Signature (Required): _____