Insurance Verification Form

VNS Therapy™

Please complete and fax completed form to (888) 577-7205

Psychiatrist Name _____
Address _____
_____
City, State, Zip Code _____
Office Contact _____

E-mail _____
Phone _____
Fax _____
Phone _____

Patient Name (Last) _____ (First) _____
Address _____ Phone _____
City, State, Zip _____ Gender _____
SSN _____ Date of Birth _____

Primary Diagnosis (please check one)

- ☐ 296.2___Major depressive disorder, single episode
- ☐ 296.5___Bipolar I disorder, depressed
- ☐ Other _____
- ☐ 296.3___Major depressive disorder, recurrent episode
- ☐ 296.89___Bipolar II disorder

	Primary Insurer	Secondary Insurer
Name of Insurance Co.		
Phone of Insurance Co.		
Subscriber's Name (if different)		
Employer/Plan Name		
Policy No.		
Group No.		
Provider Insurer ID No.		
Provider Tax ID No.		

Copy of patient's insurance card, if available:

I hereby authorize and request Cyberonics, Inc. to release the above information to the insurers identified above, to assess coverage of VNS Therapy and related health care services and to communicate those findings back to me. I understand that Cyberonics representatives will keep this information confidential and will use it for insurance assessment and insurance pre-authorization purposes only.

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Physician Signature Date