COMMUNITY STRONG LLC
307-877-2951
877-552-0705
www.communitystrongwy.com
cs@communitystrongwy.com

Referral & Authorization for Remote Patient Monitoring (RPM) and Chronic Care Management (CCM) - (Please attach Demographics and insurance)

Patient Information

Full Name: _____

Date of Birth: ____ / ____ / _____

Phone Number: _____

Address: _____

Referring Provider Information

Provider Name: _____

NPI #: _____

Address:_____

Phone: _____

Fax: _____

Clinic/Facility Name: _____

Clinic Email: _____

Care Team Contacts (MA's CNA's RN's and Office Managers – for coordination of care)

1. Name: _____ | Email: _____

2. Name: _____ | Email: _____

3. Name: _____ | Email: _____

4. Name: _____ | Email: _____

RPM and CCM Enrollment - Cardiology (ICD- 10)

Check all that apply

Hypertension

[ ] I10 – Essential (primary) hypertension

[ ] I11.0 – Hypertensive heart disease with heart failure

[ ] I15.0 – Renovascular hypertension

Heart Failure & Cardiomyopathy

[ ] I50.1 – Left ventricular failure

[ ] I50.2x – Systolic heart failure

[ ] I50.3x – Diastolic heart failure

[ ] I50.4x – Combined systolic and diastolic heart failure

[ ] I42.0 – Dilated cardiomyopathy

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Ischemic Heart Disease

[ ] I25.10 – CAD without angina

[ ] I20.9 – Angina pectoris, unspecified

[ ] Z95.1 – Presence of aortocoronary bypass graft

Arrhythmia

[ ] I48.0 – Paroxysmal atrial fibrillation

[ ] I48.2 – Chronic atrial fibrillation

[ ] I49.01 – Ventricular fibrillation

[ ] I47.1 – Supra ventricular tachycardia

Valvular & Structural Disease

[ ] I35.0 – Aortic valve stenosis

[ ] I34.0 – Mitral valve insufficiency

Lipid Disorders

[ ] E78.0 – Pure hypercholesterolemia

[ ] E78.5 – Hyperlipidemia, unspecified

Other

[ ] Z86.79 – Personal history of cardiovascular disease

[ ] Z95.9 – Presence of cardiac/vascular implant

RPM/CCM Services (please check one or both)

[ ] Remote Patient Monitoring

[ ] Chronic Care Management (Must have 2 chronic diagnoses.)

Duration of Time: 0-99 months_____.

Monitor how many times a day: _____.

Other (write-in ICD-10 or clinical reason): _____

_____.

HIPAA Compliance & Authorization to Bill

I acknowledge that I have been informed of my rights under the Health Insurance Portability and Accountability Act (HIPAA). I consent to the secure collection, transmission, and use of my health information for medical monitoring, treatment, and billing purposes.

I authorize Community Strong LLC and its billing partners to submit claims to my health insurance for Remote Patient Monitoring (RPM) services rendered and to receive direct payment for these services. I understand that my insurance may be billed monthly for monitoring services and I may be contacted by a health coach or clinician.

Patient Consent

Verbal Consent Given (initial by Staff/Provider: _____. Date: ____ / ____ / _____

Provider Signature: _____

Date: ____ / ____ / _____