Patient Enrollment

*Indicates a required field

PATIENT

*Name: (First, Middle Initial, Last) ______________________|__________|____________________

Sex: ☐ M ☐ F *DOB: _____ / _____ / _________ *Address: ____________________ Apt./Suite: _________

*City: ________________ *State: _____ *ZIP: __________ *Email: ____________________

*Cell Phone: ____________________________ Alt. Phone: ____________________________

INSURANCE Please include a copy (front & back) of all insurance cards.

Does the patient have any form of health insurance? ☐Yes ☐No

*Primary Plan Name: ____________________	Secondary Plan Name: ____________________
*Phone: ____________________	Phone: ____________________
*Member ID: __________ *Group #: __________	Member ID: __________ Group #: __________
*Cardholder Name: ____________________	Cardholder Name: ____________________
*Relationship to Cardholder:	Relationship to Cardholder:
☐Self ☐Spouse ☐Child ☐Other	☐Self ☐Spouse ☐Child ☐Other

DEVICE

☐ iPhone	☐ Android

Patient Attestation

The reSET® Connect program must have the patient's authorization to determine eligibility for patient assistance and to conduct insurance research before dispensing Access Code for reSET®. By signing below, I authorize reSET® Connect and its affiliates, as well as Envoy Health Management LLC and its affiliates ("EnvoyHealth") and any of reSET® Connect's other designated patient service and pharmacy provider(s), (referred to collectively as "reSET® Connect"), to contact me, my insurer(s), and my physician(s). I also authorize my insurer(s) and physician(s) to disclose to reSET® Connect and EnvoyHealth my protected health information, as defined within 45 C.F.R. § 160.103, including but not limited to medical records and treatment, health insurance coverage, name, address, telephone number, insurance plan, and group numbers, for the purposes described in this Attestation and Authorization for Release.

I understand that the purpose of this Attestation is so that reSET® Connect can (i) help to verify or coordinate insurance coverage or otherwise obtain payment for my treatment with reSET® 12-week digital therapy, (ii) coordinate receipt of, and payment for reSET®, (iii) facilitate my access to reSET®, (iv) provide me with information about reSET® and disease awareness and management programs and education materials, (v) manage the reSET® Connect program, and (vi) conduct market research, quality assurance, and other internal business activities.

I hereby authorize EnvoyHealth to apply for benefits on my behalf in conjunction with use of the reSET application and certify that payments may be directly sent to EnvoyHealth. Furthermore, I authorize EnvoyHealth to provide the insurer(s), including Medicare, with my name, date of birth, Social Security Number, diagnosis, insurance information, and other relevant information about me.

If the patient cannot sign, the patient's legally authorized representative must sign.

*Patient Signature: ______________________________ *Date: ____________

OR

Legally authorized
representative's signature:____________________________ Relationship:________________

For any questions, call 1-833-MY-RESET (1-833-697-3738)
or email us at PearConnect@PearTherapeutics.com

SANDOZ A Novartis Division

Once all pages are completed, please fax to 877-256-1320.

PHYSICIAN

*Name: ______________________________

*Clinic/Practice: ______________________________

*NPI #: ______________ *Tax ID #: ______________

*Contact Person: ______________________________

*Office Phone: ______________________________

*Fax: ______________________________

*Email: ______________________________

*Cell Phone: ______________________________

*Address: ______________________________

Apt./Suite: __________ *City: ______________

*State: __________ *ZIP: ______________

Preferred Method of Communication:
☐ Cell ☐ Office Phone ☐ Email

THERAPIST

Same as physician? ☐ Yes

*Name: ______________________________

*Clinic/Practice: ______________________________

NPI #: ______________ Tax ID #: ______________

Contact Person: ______________________________

Office Phone: ______________________________

Fax: ______________________________

Email: ______________________________

Cell Phone: ______________________________

Address: ______________________________

Apt./Suite: __________ *City: ______________

State: __________ ZIP: ______________

Preferred Method of Communication:
☐ Cell ☐ Office Phone ☐ Email

*Contingency Management (select one): ☐ Virtual Non-monetary Rewards ☐ Digital Monetary Gift Card Rewards
For digital monetary gift card rewards, which vendor is preferred? ☐ Amazon ☐ Starbucks ☐ Patient's Choice

DIAGNOSIS

*Diagnosis: ______________________________

*Primary ICD-10 Code: ______________________________

Secondary ICD-10 Code: ______________________________

*Previous Treatments Tried for Substance Abuse Disorder:

1. ______________________________
2. ______________________________
3. ______________________________

PRESCRIPTION

☐ *reSET® 12-week digital therapy.
Complete therapy lessons as directed.

DISPENSE: One access code good for 90-day therapy

Physician Attestation

I attest that I have obtained written permission from the patient and/or the patient's legal guardian to release the patient's protected health information to reSET® Connect as needed. I authorize EnvoyHealth Management, LLC to provide all applicable information on this form to the patient's insurer. This information is disclosed to verify insurance coverage for reSET®, provide insurance reimbursement support, and confirm eligibility for patient assistance, as well as for other reasons listed on the Patient Attestation and Authorization for Release of Information. I confirm that reSET® Connect may contact me to obtain additional information in regard to the prescription information on the form, the therapy, and reSET® Connect.

*Physician Signature: ______________________________ *Date: ______________

*Physician Name Printed: ______________________________

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