NeuraCeq®
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LantheusLink™ Enrollment Form

Please complete and fax the enrollment form to **844-339-8515** or email to **support@lantheuslink.com**. Please note that email communications sent to Lantheus or its third-party service providers may not be encrypted or secured, and safeguards established under the HIPAA Security Rule would not apply to these communications.

1 Support Requested

*Indicates required field.

☐ Patient support and insurance navigation ☐ Patient support only ☐ Insurance navigation only

- Patient support may include confirming network status with an imaging center, appointment reminders, patient education, options for transportation assistance and foundation assistance
- Insurance navigation may include benefits verification, prior authorization assistance, appeal and/or claims assistance

2 Patient Information

*First name	*Last name	*DOB (MM/DD/YYYY)	
*Address	*City	*State	*ZIP
*Preferred phone number ☐ Home ☐ Mobile	Alternate phone number ☐ Home ☐ Mobile		
Preferred language ☐ English ☐ Spanish ☐ Other	Email		
Best time to contact ☐ Morning ☐ Afternoon ☐ Evening	*Preferred contact method ☐ Call ☐ Email ☐ Text	Okay to leave voicemail ☐ Yes ☐ No	

Authorized representative ☐ **I give permission to disclose my personal health information to the following authorized representative(s)** (optional)

Representative name	Relation to patient	Phone
Representative name	Relation to patient	Phone
Representative name	Relation to patient	Phone

3 Insurance Information Attach copies of ALL of the patient's insurance card(s)

☐ Uninsured *Primary medical insurance		*Primary insurance phone number
*Plan type	*Group number	*Policy ID/MBI number
*Subscriber's name/relation (if not self)		*Subscriber's employer (if applicable)
*Secondary medical insurance		*Secondary insurance phone number
*Plan type	*Group number	*Policy ID/MBI number
*Subscriber's name/relation (if not self)		*Subscriber's employer (if applicable)

4 Referring Physician

*First name	*Last name	Practice name
*Address		Practice phone number
*City *State *ZIP		Office contact name
Office email		Office contact phone number
*Tax ID number	*Provider NPI number	Office fax number
State license number	Medicare PTAN (Provider transaction access number)	Preferred contact method ☐ Call ☐ Email ☐ Fax

5 Clinical Information Please include most recent progress note

*ICD-10 diagnosis code(s): ☐ G31.84 ☐ G30.0 ☐ G30.1 ☐ G30.8 ☐ G30.9 ☐ Other *HCPCS code ☐ Q9983

*Procedure (CPT) code ☐ 78814 ☐ 78811 ☐ Other

6 Imaging Location

Hospital/imaging center name ☐ Please check here if an order has been sent to the imaging location			
Address	City	State	ZIP
Office contact	Office contact phone number	Office contact email	
Billing contact	Billing contact phone number	☐ Outpatient ☐ Independent scan facility	
Preferred contact method ☐ Call ☐ Email ☐ Fax	Fax number	Anticipated scan date	
Tax ID number	Imaging center NPI number	Medicare PTAN (Provider transaction access number)	

7 Permission to Provide Lantheus Link Services

*Indicates required field.

By signing, I enroll in Lantheus Link patient support services ("Services") related to my ordered procedure, which may include educational resources, case management support, and information on potentially available out-of-pocket cost support. Lantheus Link will gather information about me, including information related to my medical condition and treatment, care management, health insurance and coverage claims, and order for my procedure, as well as all information provided on this form (together "My Information"). I understand that Lantheus Link may:

- Review and verify my insurance coverage for my ordered scan.
- Inform me about potentially available transportation and financial assistance options.
- Provide appointment reminders for my ordered scan.
- Share educational and promotional materials about the Services which may be based on the information I provide, including any health information I share on the form above.
- Conduct quality assurance and seek feedback related to the Services.
- Use de-identified information for research and business improvements.

Lantheus Link Services may change at any time. For more information on how we use personal information, please contact the Lantheus Privacy Office by emailing privacy@lantheus.com.

I can opt out of communications or services at any time by calling 844-339-8514 or emailing support@lantheuslink.com. This will not apply to any prior use of My Information.

☐ **I agree to receive text messages from Lantheus as part of Lantheus Link Patient Support Services.**

By opting in, I consent to receive text messages at the number I provided on this form. Standard message and data rates may apply. Text "STOP" to opt out at any time.

» _____ _____ _____

*Patient signature/legal guardian signature | *Date | Printed name/relationship to patient (if applicable)

8 Permission to Share Health Information

By enrolling in Lantheus Link, I authorize my health insurance, physicians, and other healthcare providers ("Providers") to share My Information with Lantheus, its affiliates, and partners to enroll me in Lantheus Link, provide program services and conduct quality assurance and other business activities. Lantheus Link may use my de-identified information for internal analysis or research purposes. I understand that federal privacy laws may not protect My Information from further disclosure once disclosed to Lantheus Link, but Lantheus Link has agreed to only use it as allowed by me in this authorization or required by law. Signing this form is voluntary and will not affect my ability to obtain medical treatment, my eligibility for insurance benefits, or coverage under my health insurance, or access to Lantheus products including my ordered procedure. Without this authorization, Lantheus Link cannot provide Services to me. Unless revoked, this authorization expires one year from the date signed, or earlier if required by law. I understand that I may revoke this authorization at any time by emailing such cancellation to support@lantheuslink.com or calling 844-339-8514; however, this cancellation will not apply to My Information already used or disclosed before notice of cancellation is received by Lantheus Link. I understand that I am entitled to a copy of this form.

» _____ _____ _____

*Patient signature/legal guardian signature | *Date | Printed name/relationship to patient (if applicable)

9 Physician Legal Consent/Agreement

By signing, I confirm that the patient named on this form is under my care, and the information provided is accurate to the best of my knowledge. The ordered diagnostic procedure is medically necessary and aligns with FDA-approved labeling. I have obtained written authorization from my patient or their representative, as required by state and federal law, including HIPAA and its implementing regulations, to share the health information on this form with Lantheus Link for: (1) Verifying insurance coverage and eligibility for the ordered procedure, (2) confirming network status with imaging centers for the ordered product, and (3) introducing related services to my patient and contacting them for these purposes. I acknowledge that I am not obligated to order any Lantheus products and have not received nor will receive any benefit from Lantheus for doing so. I consent to being contacted by Lantheus Link via fax, phone, mail, or email to assist the above-named patient and/or to provide me with additional program information. I understand that Lantheus may change or end program services without notice.

» _____ _____

*Physician signature | *Date

For more information, visit lantheuslink.com or call 844-339-8514.
Please return completed form by fax to 844-339-8515 or email to support@lantheuslink.com.

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