

# Fax Cover Page

To: **NNCIP Plan Coordinator** From: \_\_\_\_\_  
(Please Print Full Name)

Fax: **1-866-424-5159** No. Pages: \_\_\_\_\_  
(No of pages will be verified)

Email: **Forms@nncip.com** Date: \_\_\_\_\_  
(mm/dd/yyyy)

Phone: **1-800-846-6560**

Re: **Enrollment Forms, Records & ID**

Urgent       For Review & Eligibility Assessment

● Additional Comments:

---

## Checklist

(To expedite processing, please be sure to complete and check-off the following)

- Complete Online Enrollment at [www.nncip.com](http://www.nncip.com) click on: **Enroll online now**
- Fax or email** Drivers License (Please be sure that your photo is clear, enlarge and lighten if necessary. Please use a scanner if possible. Address must be current or explain above!)
- Complete and **Fax or email** HIPAA Authorization Form (even if you have records and you fax them in, we still need this form authorizing all current and recent pain treatment providers and pharmacies)
- Complete and **Fax or email** Payment Authorization Form, be sure to initial PHARMACY AUTHORIZATION section if requested (this is for your convenience only)
- Complete and **Fax or email** Patient Enrollment Interview (this will help your doctor assess your eligibility for the first appointment and for continued treatment)
- Gather all general medical records, radiological/imaging reports dating back at least (3), three months and up to (2) two years and **Fax or email** along with other forms

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION  
(PLEASE PRINT CLEARLY)

PATIENT/AUTHORIZER INFORMATION: (Print, complete and sign this form, include **each and every provider** even if **YOU** provide the records)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Current address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of birth: \_\_\_\_\_ mm/dd/yyyy

REQUEST FOR RELEASE (Patient signature required)

By evidence of **signature** below, the above named **patient** requests medical records as specified below be released to **National Network for Chronic Intractable Pain, ("NNCIP")** for the purpose of continuity of care and to facilitate research into the long-term effectiveness of current protocols as well as the efficacy of alternative therapies for patients with chronic medical complaints. Patient expressly releases this information pertaining to ALL CURRENT AND RECENT TREATMENT INVOLVING PAIN to NNCIP. (Check all that apply)

- Required - All general medical records, radiological reports, and lab reports dating back at least (3), three months up to (2), two years.
- Required - Pharmacy records dating back at least (3), three months up to two years.
- Limited records: (specify & explain the reason why only limited records are being released to NNCIP)

- Including psychiatric/psychological records. (if applicable)
- Including HIV/AIDS records, (if applicable) Patient signature: \_\_\_\_\_
- Other pertinent records: \_\_\_\_\_

This authorization is valid from: (today's date) \_\_\_\_\_ and expires on: \_\_\_\_\_ mm/dd/yyyy (typically one year)

PATIENT SIGNATURE (**Required**): \_\_\_\_\_ DATE: \_\_\_\_\_ mm/dd/yyyy

CURRENT & PREVIOUS PROVIDER INFORMATION - IDENTIFY **EVERY PROVIDER INCLUDING ALL PAIN RELATED TREATMENT** YOU HAVE RECEIVED DURING AT LEAST THE LAST THREE CONSECUTIVE MONTHS AND INCLUDING THE LAST TWO YEARS (**DISCLOSURE OF ALL PROVIDERS REQUIRED**)

IDENTIFICATION OF **PRIMARY** CARE PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED

(All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

IDENTIFICATION OF **PHARMACY** FROM WHOM RECORDS ARE BEING REQUESTED

(All contact information is REQUIRED for each pharmacy even if **YOU** are providing the records)

Name of Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Pharmacy address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last Prescription/Refill: \_\_\_\_\_ mm/dd/yyyy

IDENTIFICATION OF **SPECIALIST** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED

(All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

## HIPAA AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

CURRENT & PREVIOUS PROVIDER INFORMATION – CONTINUED - (DISCLOSURE OF ALL PROVIDERS REQUIRED)

### IDENTIFICATION OF **OTHER** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED (All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

### IDENTIFICATION OF **OTHER** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED (All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

### IDENTIFICATION OF **OTHER** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED (All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

### IDENTIFICATION OF **OTHER** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED (All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

### IDENTIFICATION OF **OTHER** PROVIDER FROM WHOM RECORDS ARE BEING REQUESTED (All contact information is REQUIRED for each provider even if **YOU** are providing the records)

Name of Provider: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Organization, Facility, or affiliation: (if different than provider) \_\_\_\_\_  
Provider address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Date of last visit/consult: \_\_\_\_\_ mm/dd/yyyy

### ACKNOWLEDGEMENT OF PROHIBITION ON REDISCLOSURE

NNCIP acknowledges that this information is being disclosed from records whose confidentiality is protected by law. State and federal laws prohibit us from making any further disclosure of such information without the consent of the person to whom such information pertains, or as otherwise permitted by such laws. With regard to HIV/AIDS and psychiatric/psychological records (if applicable), a specific, written consent or a court order is required. A general authorization for the re-release of medical or other information is NOT sufficient for this purpose.

### ADMINISTRATIVE INSTRUCTIONS

NNCIP requests the authorized records above including a copy of this document be faxed to: 1 (866) 424-5159  
NNCIP, L.L.C. 7075 W. Bell Rd. Suite 7, Glendale, Arizona 85308  
Phone: 1 (800) 846-6560 Fax: 1 (866) 424-5159



# PAYMENT AUTHORIZATION FORM

Office: 1-800-846-6560 Fax: 1-866-424-5159

To: **NNCIP Plan Coordinator**

For your convenience, we accept **VISA®**, **MasterCard®** & **DISCOVER®**. As an approved medical services provider, we accept **FSA**: Flexible Spending Account, **HBC**: Health Benefit Card, **HRA**: Health Reimbursement Arrangement, **HSA**: Health Savings Account, **TPA**: Third Party Administrator and more...



## CREDIT CARD AUTHORIZATION SECTION

Credit Card Type: (check only one)  **-VISA**  **-MASTERCARD**  **-DISCOVER**

Credit Card Number:

--	--	--	--

Exp. Date: \_\_\_\_\_ we will call you for CVV/CVC as required (we do not retain CVV/CVC)  
(mm/dd/yyyy)

Name on Card: \_\_\_\_\_ (please print)

Billing Address: \_\_\_\_\_  
(Street, city, state, zip)

Authorized Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_ (mm/dd/yyyy)

I approve and authorize NNCIP to charge my credit card within 1-2 days prior to each scheduled appointment. If doctor does not continue my treatment, all charges less the consultation fee may be fully refunded upon written request and upon review of circumstances concerning the discontinued treatment.

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Primary Email: \_\_\_\_\_ Other Email: \_\_\_\_\_

## PHARMACY "THIRD PARTY" AUTHORIZATION SECTION

Patient Initials here: \_\_\_\_\_ I further approve and hereby authorize NNCIP to forward this form and provide my payment information to the pharmacy of my choosing. I understand that this is at my request and for my convenience. I understand that if I do not initial above, that I may be required to provide the pharmacy with my payment information each time I require services. I hereby release NNCIP from any liability should my payment information be compromised by the pharmacy.

## NNCIP PATIENT ENROLLMENT INTERVIEW FORM

Please answer all of the following questions **honestly and completely**, include as much detail as possible. The information you provide will help determine your eligibility for membership and will help your doctor plan your treatment. This form is protected by HIPAA and will become part of your medical records. **Please print legibly with dark pencil or ink pen.** Fax this completed form along with your ID, Payment Authorization and HIPAA release forms to: **1-866-424-5159.**

Your last name: \_\_\_\_\_, first name: \_\_\_\_\_ (please print)

1. What treatments have you already tried to relieve your chronic pain?

---

---

---

2. Have you ever used the Internet to order medications for pain or anxiety? (if yes, how long did you use the Internet service and when was your last order)

---

---

---

3. Please explain any apprehensions or concerns that you might have about your doctor's appointment or the NNCIP coordinating program?

---

---

---

4. Are you currently a patient of any other doctor(s)? If yes, please explain why, if not, please explain why you left or were discharged your previous doctor(s) care:

---

---

---

5. List any possible or scheduled surgeries? (Major, Minor, Dental, Cosmetic, etc.) If so, please list dates:

---

---

---

6. List any planned or scheduled trips/vacations within the next year? If so please state dates and destinations:

---

---

---

7. Explain what have you been doing to manage your pain for the last few months?

---

---

---