ZIMMER BIOMET
Your progress. Our promise.™

Gel-One Solutions ENROLLMENT FORM

Customer Service: (855) 200-2760 | **Fax completed form to:** (855) 200-2761

For real-time status updates register at **gelonesolutions.com**

*Indicates required field

REQUESTED INVESTIGATION (Select one option ONLY)

☐ **Buy and Bill:** Run Insurance Benefits Investigation in order to Buy and Bill

☐ **Pharmacy Dispense:** Run Insurance Benefits Investigation and dispense Gel-One® through the Pharmacy

Additional Information:

PATIENT INFORMATION

*Patient Name (Last, First):

*Date of Birth: Gender: M ☐ F ☐

*Address: SSN:

*City: *State: *Zip:

*Phone: Cell:

Email:

PRESCRIPTION INFORMATION

*Patient Name (First, Last):

Drug: **Gel-One® (Cross-linked Hyaluronate)** Date:

Quantity: Refills:

Injection site: ☐Right Knee ☐Left Knee ☐Bilateral

*Sig (Directions): Inject one 3mL syringe (1% solution [10 mg/mL], 30mg total hyaluronan) into the intra-articular space of the affected knee.

PROVIDER ATTESTATION

By my signature below, I verify that the information being disclosed in this enrollment form is complete and accurate to the best of my knowledge. I understand that Armada Specialty Pharmacy Network reserves the right at any time and for any reason, without notice, to modify this enrollment form or to modify or discontinue any services or assistance provided through this Program. Finally, I authorize ASPN and Zimmer as my designated agent to use and disclose my patient's protected health information as may be necessary for treatment, payment, and healthcare operations, including to verify the accuracy of any information provided, to verify patient eligibility, to provide for payment and reimbursement, and to forward the above prescription information, by fax or other mode of delivery, to a pharmacy for fulfillment. Finally, I allow ASPN and Zimmer to email me regarding prescription status updates and act as my prior authorization agent in dealing with prescription and medical insurance companies.

*Prescriber's Signature

(Dispense As Written)

*Date of Signature

For real-time access to status updates on your Gel-One claims, register your office at **gelonesolutions.com**

PHARMACY INSURANCE INFORMATION

*Insurance Name: Pharmacy Help Desk:

Policyholder Name: *Relationship to Patient:

*Member ID: *Group ID:

*Rx BIN: *PCN:

MEDICAL INSURANCE INFORMATION

*Primary Insurance: *Phone:

*Member ID: *Group ID:

Secondary Insurance: Phone:

Member ID: Group ID:

PRESCRIBER INFORMATION

*Prescriber Name (Last, First):

*NPI: ☐ In network ☐ Out of network

*Prescriber Phone: *Fax:

*Address:

*City: *State: *Zip:

Email:

*Tax ID: *PTAN:

PRESCRIBER OFFICE CONTACT INFORMATION

*Office Contact Name (First, Last):

*Email: *Phone:

CLINICAL INFORMATION (Required information)

Diagnosis Code(s):	Administration CPT Code(s):

Has the patient received prior HA treatments? ☐Yes ☐No

Site(s) previously treated: ☐Right Knee ☐Left Knee ☐Bilateral

Date(s) of prior treatments:

Product(s) used:

Scheduled Date of Treatment:

Would you like us to initiate the PA? ☐Yes ☐No