

ARC^{EX} Reimbursement Support

Program Overview

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The program is administered by PRIA Healthcare on behalf of ONWARD Medical to provide reimbursement support services related to ARC^{EX} Personal System for home use.

Additional features of the program include:

- Secure online portal for order submission and tracking
- Real-time order updates and streamlined communication
- Comprehensive benefits verification
- Prior authorization submissions
- Appeals of prior authorization denials
 - Internal Appeals
 - External Reviews [Conducted by Independent Review Organization (IRO)]

Enroll to Submit Orders in a Few Easy Steps

1 Scan the QR to enroll online at <https://priaenrollment.com/ARC-EX>

Or you may enroll by completing the Provider Enrollment Form and sending by email to ARC-EX@priahealthcare.com or by fax to



2 Once the ARC^{EX} Reimbursement Support Program receives your enrollment form, you will receive a welcome email that includes the following:

- Login Instructions
- Portal Guide
- Order Submission Checklist
- Order Intake Form (if not submitting via portal)

<https://priahealthcare.my.site.com/ARCEX>

P 860.781.9033

F 860.321.1499

ARC-EX@priahealthcare.com



Participation in the ARC^{EX} Reimbursement Support Program does not guarantee coverage, reimbursement, prior authorization approval, or payment. Coverage decisions are made solely by the individual's health plan.
029930 v1



ARC^{EX} Personal System

Prescription / Written Order

Date of order

Patient information

Patient legal name

Date of birth

Clinical information

Primary diagnosis ICD-10 code

Secondary diagnosis ICD-10 code(s)

Date of injury

Level of injury

ASIA Impairment Scale (AIS) Classification

Prescription/Order Details

I am prescribing the following items as medically necessary:

Item	SKU	Quantity
☐ ARC ^{EX} Personal Transcutaneous Spinal Cord Stimulator System	EXSYS01PERUS	1
☐ Axelgaard PALS Active Electrodes (round, pack of 4)	879100	10
☐ Axelgaard PALS Return Electrodes (rectangle, pack of 4)	895240	10

Electrode refills as needed for duration of therapy

Prescriber Information

Name

NPI number

Address

Email

Phone

By my signature below, I attest that I am the treating provider identified above and the prescribed items are reasonable and medically necessary as part of treatment for this patient. I have reviewed this written order and certify all information is true and accurate to the best of my knowledge.

Signature

Date

Signature and date stamps are not accepted. Please provide a handwritten or compliant electronic signature and date.