# CoaguChek® Patient Services Enrollment Guide

*Four easy steps to enrolling patients in CoaguChek Patient Services*

## 1 The healthcare professional provides patient information

The healthcare professional submits the Physician Order Form and Patient Insurance Data online using CoaguChek Link (coagucheklink.com) or by fax.

## 2 The patient provides authorization

The patient faxes or mails us the Patient Authorization Form to allow CoaguChek Patient Services to confirm their coverage, prior authorization, and estimated out-of-pocket costs.

## 3 CoaguChek Patient Services confirms coverage with patient

We contact the patient with an estimated out-of-pocket cost and let the healthcare professional know if the patient decides not to pursue self-testing.

## 4 CoaguChek Patient Services schedules patient training

Patients can be trained in the clinic by the patient's physician office or at home by one of our certified trainers. During training, patients learn the importance of testing as prescribed and how to:

- Use the meter
- Report test results
- Order supplies

*Patient enrollment status can be viewed online at coagucheklink.com

CoaguChek® Patient Services
Provided by Roche Health Solutions Inc.

CoaguChek®

**Phone: 1-800-780-0675**
**www.coaguchekpatientservices.com**

CPS Account #_____

# PATIENT AUTHORIZATION FORM

**Complete the patient information section • Read the entire form • Sign and date where indicated • Mail or fax the completed form to CoaguChek® Patient Services (see below)**

| PATIENT FIRST NAME | MI | LAST NAME | GENDER ◯M ◯F | DOB (mm/dd/yyyy) |
|---|---|---|---|---|
| | | | | |

| HOME ADDRESS | CITY | STATE | ZIP/POSTAL CODE |
|---|---|---|---|
| | | | |

| PHONE # | SECONDARY PHONE# (if applicable) | E-MAIL (if available) |
|---|---|---|
| 1– | 1– | |

## ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

**CoaguChek Patient Services provided by Roche Health Solutions Inc. performs billing of Medicare, Medicaid and other insurance as a service. To agree to this service, read the following statement, then sign and date below.**

I authorize Roche Health Solutions Inc. to directly bill Medicare, Medicaid and other insurance on my behalf. Furthermore, I authorize Medicare, Medicaid and other insurance to pay benefits on my behalf directly to Roche Health Solutions Inc. for items and services provided to me by Roche Health Solutions Inc., through the regional office that serves my state or region as identified on the CoaguChek Patient Services Regional Offices map.

I agree to notify Roche Health Solutions Inc. immediately of any changes in insurance coverage. I agree to pay all amounts owed to Roche Health Solutions Inc. that are not covered by Medicare, Medicaid or other insurance, including applicable co-payments and deductibles for which I am responsible. I understand that if Roche Health Solutions Inc. is out of network with my insurance, I have the option to get my care at either an in-network or an out of network provider. I understand that when receiving care out of network for products or services covered by my benefit plan, my insurer may impose a higher deductible and higher copayments than if I received services from a network provider. I understand and agree that, regardless of my insurance status, I am ultimately responsible for understanding my insurance benefits and for the balance of my account.

I authorize any holder of medical or other information about me to release to Roche Health Solutions Inc. or its billing agent any information for this and any related health claim. Furthermore, I authorize Roche Health Solutions Inc. to release medical or other information about me for the purpose of obtaining payment from Medicare, Medicaid or other insurance and their agents and assignees. Such records may be released to any individual or entity authorized to receive such information.

I agree to permit a fax or other copy of this form to serve as an original. Upon request, a copy of this form may be sent to Medicare, Medicaid or other insurance and their agents or assignees. Roche Health Solutions Inc. will keep the original form on file. I understand that this authorization will remain in effect until revoked by me in writing.

## SIGNATURE REQUIRED

| **SIGNATURE** | TODAY'S DATE (mm/dd/yyyy) |
|---|---|
| SIGN ▶ | |

If signed by someone other than the patient, I attest that I have the authority to sign on behalf of the patient.

Save space for office use only.
Will not print.


***CoaguChek*® Patient Services**
Provided by Roche Health Solutions Inc.

www.coaguchekpatientservices.com • www.TestYourINR.com





dms_mr_001FM1 (DMS-1545) 573-52292-0313


**Please mail or fax completed form to the central office.***


CoaguChek Patient Services
11800 Exit 5 Parkway, Suite 122
Fishers, IN 46037

**Phone: 1-800-780-0675**
**Fax: 1-800-779-8560**


*You may also send this form to your regional office. Please refer to the CoaguChek Patient Services Regional Offices map.

**REFER TO INSTRUCTIONS TO COMPLETE** Org ID: _____ CPS Account # _____

# PHYSICIAN ORDER FOR PT/INR PATIENT SELF-TESTING

**• Complete all sections • Sign and date form • Mail or fax the completed form to CoaguChek® Patient Services (see below)**

○ New Prescription ○ Prescription Reactivation ○ Change Physician ○ Change Test Frequency

**1**

| PATIENT FIRST NAME* | MI | LAST NAME* | GENDER ○M ○F | DOB (mm/dd/yyyy)* |
|---|---|---|---|---|
| | | | | |

| HOME ADDRESS* | CITY* | STATE* | ZIP/POSTAL CODE* |
|---|---|---|---|
| | | | |

| PRIMARY PHONE # | SECONDARY PHONE # (if applicable) | PATIENT EMAIL (if available) |
|---|---|---|
| 1– | 1– | |

## PATIENT DIAGNOSIS CODE* (complete all that apply)

**2**

| | Diagnosis Code (Required) | Description (not required) |
|---|---|---|
| 1* | | |
| 2 | | |
| 3 | | |
| 4 | | |
| ☐ | Long-Term (current) use of anti-coagulants† | |

† To be eligible for coverage, certain payers may require the prescriber to confirm.
Note: Entry of a non-covered diagnosis code (per patient's insurance coverage) may result in a delay in start of service.
Refer to PSTRx.com for a list of diagnosis codes currently covered for Patient Home INR Monitoring.

## MEDICAL INFORMATION

**3** **Start of warfarin therapy*:**

Greater than 3 months ○ Yes ○ No

**Note:** Patient must have been on oral warfarin therapy for more than 3 months.

## THERAPEUTIC / NOTIFICATION RANGES

**4** **INR therapeutic range***

**LOW*:** _____

**HIGH*:** _____

**5** **INR notification range**

**BELOW:** _____

**ABOVE:** _____

## PRESCRIBED FREQUENCY

**6** **Tests per month (select one)***

*While patient self-testing can be prescribed at any frequency, the following options are offered:*

○ 4 ○ 3 ○ 2 ○ 2–4

**Note:** Medicare will cover up to one test per week.

**7**

| CONTACT FOR PATIENT RESULTS | TITLE | PHONE (OUT OF RANGE)* | FAX (ALL RESULTS)* | CONTACT EMAIL |
|---|---|---|---|---|
| | | 1– | 1– | |

**Clinic Contact's preferred method for receiving Test Results.** ☐ On-line thru CoaguChek Link ☐ Fax

## PATIENT TRAINING – Face-to-face training is required (select one of the options below)*

**8**

○ By Clinic/Practice ○ By CoaguChek Patient Services ○ Physician certifies patient was face-to-face trained on the CoaguChek XS

## PHYSICIAN AUTHORIZATION (signature and date must be hand-written or esigned)

This form serves as a Physician's Order for the CoaguChek XS System for Patient Self-Testing and related supplies. I certify that this patient has been on oral warfarin therapy for more than 3 months and is a suitable candidate for self-testing. At this time, the patient or his/her caregiver has no condition that makes self-testing unsafe (e.g., cognitive and/or physical disorders). I agree to notify CoaguChek Patient Services if self-testing is no longer prescribed for this patient.

**9**

| SIGN ▶ PRESCRIBING PHYSICIAN SIGNATURE* | DATE (mm/dd/yyyy)* | PHYSICIAN NPI# |
|---|---|---|
| | | |

| PRESCRIBING PHYSICIAN PRINTED* | PRACTICE/CLINIC NAME |
|---|---|
| | |

| CLINIC STREET ADDRESS* | SUITE # | CLINIC CITY* | CLINIC STATE* | CLINIC ZIP* |
|---|---|---|---|---|
| | | | | |

| PHYSICIAN PRIMARY PHONE # | PHYSICIAN FAX # | PHYSICIAN EMAIL ADDRESS |
|---|---|---|
| 1– | 1– | |

# INSURANCE INFORMATION

**10**

**Note: For patients with private insurance coverage, please provide 3 months of clinical notes with Rx submission**

## PRIMARY HEALTH INSURANCE INFORMATION

| INSURANCE COMPANY | POLICY ID # | CUSTOMER SERVICE PHONE # |
|---|---|---|
| | | 1– |

## SECONDARY HEALTH INSURANCE INFORMATION

| INSURANCE COMPANY | POLICY ID # | CUSTOMER SERVICE PHONE # |
|---|---|---|
| | | 1– |

○ No Insurance Coverage **Note: copy of front & back of patient insurance card with Clinic Face Sheet also accepted**

***To avoid delay in processing, completion of this field is required.**

**Please mail or fax completed form to the central office.‡**

CoaguChek® Patient Services
Provided by Roche Health Solutions Inc.

CoaguChek Patient Services
11800 Exit 5 Parkway, Suite 122
Fishers, IN 46037

**Phone: 1-800-780-0675**
**Fax: 1-800-779-8560**

‡ Your patient will be served by the applicable regional office. Please refer to the CoaguChek Patient Services Regional Offices map. (coaguchekpatientservices.com)

www.coaguchekpatientservices.com • www.TestYourINR.com



dms_mr_025FM1 (ver03) 573-53115-0314

# Instructions for completing patient enrollment for Home PT/INR Monitoring with CoaguChek Patient Services

**For easy, on-line patient enrollment, go to www.CoaguCheklink.com**
To request a username and temporary password, please call 800-780-0675

## Patient Information

(1) **Patient Information:** Complete Patient Name, Gender, DOB, Address, Primary/secondary Telephone #. Patient email address is requested if available.

## Patient Diagnosis Code

(2) Enter all Diagnosis Codes on the Physician Order (section 2) that apply from the list below. **Only the codes listed are currently covered for Patient Home INR Monitoring. Entering other codes will result in processing delays.**

| | |
|---|---|
| **Organ/tissue replaced by other means** | |
| • Mechanical heart valve | V43.3 |
| **Atrial Fibrillation** | |
| • A. Fib (established) (paroxysmal) | 427.31 |
| **Other venous embolism and thrombosis** | |
| • Budd-Chiari (hepatic vein thrombosis) | 453.0 |
| • Thrombophlebitis migrans | 453.1 |
| • Vena cava | 453.2 |
| • Renal vein | 453.3 |
| • DVT LE NOS | 453.40 |
| • DVT proximal LE<br>- Femoral, iliac, popliteal; thigh, upper leg NOS | 453.41 |
| • DVT distal LE<br>- Calf, lower leg NOS; peroneal, tibial | 453.42 |
| • DVT UE; superficial | 453.81 |
| • DVT UE; deep veins | 453.82 |
| • DVT UE; unspecified | 453.83 |
| • DVT; axillary | 453.84 |
| • DVT; subclavian | 453.85 |
| • DVT; internal jugular | 453.86 |
| • DVT; other thoracic | 453.87 |
| • DVT; other specified veins _____ | 453.89 |
| • DVT LE; unspec. site | 453.9 |
| **Other diseases of blood/blood-forming organs** | |
| • Primary hypercoagulable state | 289.81 |
| **Phlebitis and thrombophlebitis** | |
| • Superficial vessels LE's: saph vein (greater)(lesser) | 451.0 |
| • Femoral vein (deep)(superficial) | 451.11 |
| • Other femoropopliteal, popliteal, tibial vein | 451.19 |
| • LE, unspec. | 451.2 |
| • Iliac vein | 451.81 |
| • Superficial veins, UE's / antecubital, basilic, cephalic | 451.82 |
| • Deep veins, UE's / brachial, radial, ulnar | 451.83 |
| • UE's / unspecified | 451.84 |
| • Other<br>- Axillary, jugular, subclavian vein<br>- Thrombophlebitis of breast (Mondor's) | 451.89 |
| • Unspec. site | 451.9 |
| **Pulmonary embolism and infarction** | |
| • Iatrogenic | 415.11 |
| • Septic | 415.12 |
| • Other pulmonary embolism and infarction | 415.19 |

## Medical Information

(3) Check yes or no box indicating **Start Date of Warfarin Therapy** as greater than 3 months
**Note:** Patient must have been on oral warfarin therapy for a minimum of 3 months

(4) Enter the prescribed **Low and High Therapeutic INR Range** for patient

(5) Indicate when you would like to be notified of a patient's INR result below ___ or above ___.

(6) **Prescribed Frequency**, or Tests per Month offered by CPS are: **4/mo, 3/mo, 2/mo, 2-4/mo**
**Note:** Medicare will cover up to one Home INR test per week.

(7) **Clinic Contact for Results and Notifications:** Please enter the contact name and contact information for communication of results and preferred method to receive results. This contact information will also serve as the primary clinic contact information. If the fax option is selected, all results will be faxed and the contact will be called if results meet the notification criteria. If CoaguChek Link is used, all results will be viewable in CoaguChek Link as they are reported by the patient and alerts will be sent if result meets notification criteria. To request access to CoaguChek Link, please call 1-800-780-0675. The default reporting option is fax.

## Patient Training

(8) Face-to-face training is required. Please indicate **<u>one</u>** of the following patient training option:
**A)** By Clinic/Practice **(Practice must complete certification training and agreement)**
**B)** By CoaguChek Patient Services
**C)** If patient has been previously trained on use of CoaguChek XS, physician may certify that patient received face-to-face training.

## Physician Authorization

(9) Prescribing Physician's signature and date signed, enter Physician NPI #, Printed Physician Name, Clinic/Practice address, Physician's Primary Phone, Fax and e-mail address.

## Insurance Information

(10) Indicate Insurance Company, Policy ID# and Customer Service Phone # (copy of front & back of patient insurance card with Clinic Face Sheet also accepted). No physician signature is required for enrolled patients only updating insurance information.

## Patient Enrollment Checklist

### Health Care Provider

☐ **Physician Order:** completed with hand-written or electronic signature

☐ **Insurance Information:**
– Patient Face Sheet with insurance information or front/back of Patient Insurance Card also accepted. Please fax along with the **Physician Order**

☐ Additional patient clinical information as required by commercial insurance provider

### Patient

☐ **Patient Authorization Form:** completed and signed
– CoaguChek Patient Services will mail the Authorization Form to patient for signature if it is not submitted with the Physician Order.

☐ Fax forms to CoaguChek Patient Services at **1-800-779-8560**. Or mail forms to: **CoaguChek Patient Services, 11800 Exit 5 Parkway, Suite 122, Fishers IN 46037**

If you have any questions, please contact CoaguChek Patient Services at **1-800-780-0675**.