PATIENT SERVICES INC. *"Making the Gift Of Health A Lifetime Benefit"*

MEDICAL CARE PROVIDER STATEMENT

The following information is required from the medical provider to process the PSI financial assistance application for:

Patient Name: ____ DOB: ____________________

DIAGNOSIS AND TREATMENT Please indicate the patient's diagnosis for which you are treating:

- ❑ aHUS
- ❑ Alpha-1 Antitrypsin Deficiency
- ❑ Cardiovascular disease
- ❑ Circadian Rhythm Disorder
- ❑ CIDP
- ❑ Corneal Cystine Crystal Accumulation in Cystinosis
- ❑ Fabry
- ❑ Gaucher's Disease
- ❑ HAE - Acute
- ❑ HAE - Prophylactic
- ❑ Hypoparathyroidism
- ❑ Idiopathic Pulmonary Fibrosis
- ❑ Kidney Stones
- ❑ Lysosomal Acid Lipase Deficiency
- ❑ Malignant Ascites
- ❑ Metastatic Melanoma
- ❑ Metastatic Renal Cell Carcinoma
- ❑ MPS1
- ❑ Pleural Effusion
- ❑ PNH
- ❑ Pompe
- ❑ Primary Immune Deficiency
- ❑ Pseudobulbar Affect
- ❑ Other ______________________________

Bleeding Disorders diagnoses: ❑ Glanzmann's Thrombasthenia ❑Glanzmann's Thrombasthenia with refractoriness to platelets

❑ Hemophilia ❑ Hemophilia with Inhibitors ❑ vonWillebrands

Factor Deficiency: ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 13 Type: ❑ Type 1 ❑ Type 2 ❑ Type 3

Severity: ❑Mild ❑Moderate ❑Severe

Breast Cancer Screening

Patient is prescribed an MRI due to:

- ❑ A high genetic predisposition to Breast Cancer through BRCA positive testing
- ❑ A verifiable family history
- ❑ A high genetic predisposition to Breast Cancer through BRCA positive testing and a verifiable family history
- ❑ Other ____

PRESCRIBED TREATMENT for the diagnosis selected above (based upon most recent records):

Product	Dosage	Frequency	Route
______________	______________	______________	______________
______________	______________	______________	______________

PHYSICIAN INFORMATION:

Physician's Name (please print):____

Address:____

City:________________________________ State:__________ Zip: ______________

Phone Number: ____________________________ Fax Number: ____________________________

Name of person completing form (please print): ____________________________

Title of person completing form (please print): ____________________________

Physician/Representative Signature: ____________________________ Date: ______ / ______/ ______

Medical Office Tax ID #____

Thank you for your prompt attention to this request. Please return this completed and signed form to PSI via email, fax, or mail.