PATIENT SERVICES
INCORPORATED

# Medical Care Provider Statement

The information below is required to process a Patient Services, Inc. (PSI) financial assistance application. This form must be completed by the applicant's medical provider and may be submitted to PSI via secure portal upload, encrypted email, fax, or mail.

## Part A: Patient Information *(To be completed by Provider)*

Patient Name: _____

Date of Birth: _____ PSI Patient ID or Last 4 digits of SSN: _____

Diagnosis for which you are treating*: _____

Diagnosis (ICD-10) Code: _____

**If patient is seeking assistance in the Breast Cancer Screening program, please indicate the reason for prescribing MRI.*

## Part B: Prescribed Treatment

*Please list the FDA approved and indicated product(s) that the applicant's medical provider has prescribed for the diagnosis listed above. If the patient is not currently being treated on-label, please provide the reason (i.e. undergoing diagnostic testing, etc.) under the Product section.*

| Product | Dosage | Frequency | Route |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## Part C: Provider Information & Certification *(Please print)*

Provider Name and Credentials: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Name of person completing form: _____

Title of person completing form: _____

By signing this form, I certify that:

- The patient listed above has been diagnosed by his or her medical provider with the condition listed above.
- The patient is currently being treated for this condition with the FDA-approved products listed on this form.
- The patient's diagnosis and treatment were determined solely and independently by his or her medical provider based on clinical best interest of the patient, prior to the submission of this form or any communications with PSI regarding the possibility of financial assistance.
- I understand that financial assistance is available for any underlying and FDA-approved treatment for the condition listed above.

Provider's Signature: _____ Date: _____ / _____ / _____



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