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: _____

Part B: Prescribed Treatment *(To be completed by Provider)*

Please list the FDA approved and indicated medication(s) that the applicant's medical provider has prescribed for the diagnosis listed above.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____

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

Name of person completing form: _____

Title of person completing form: _____

Provider Office Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

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 and indicated treatments 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 may be available for FDA-approved and indicated treatments for and related to the patient's condition.

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

Provider Printed Name and Credentials: _____