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. If sending via fax, please send to (804)744-9388.

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

Patient Name: _____ Date of Birth: _____

Diagnosis for which you are treating: _____

Diagnosis (ICD-10) Code: _____

Part B: Provider Information & Certification *(All fields are REQUIRED. Please print clearly.)*

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'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: _____ Provider Credentials: _____
(Example: MD, DO, NP, etc.)

Phone Number: _____ Fax Number: _____

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