An affordable option for patients needing anticoagulation therapy†

Roche Point of Care

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

1-800-780-0675 ▪ coaguchekpatientservices.com

Roche Health Solutions
9115 Hague Road
Indianapolis, IN 46256
coaguchekpatientservices.com

†Patient self-testing services are typically covered by Medicare and most insurance providers Actual coverage, reimbursement and out-of-pocket costs depend on a number of factors and vary by plan.

CoaguChek® Patient Services
Provided by Roche Health Solutions Inc.

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.

CoaguChek® Patient Services
Provided by Roche Health Solutions Inc.

www.coaguchekpatientservices.com

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

CoaguChek Patient Services
9115 Hague Rd
Indianapolis, IN 46256

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.

CoaguChek® Patient Services
Provided by Roche Health Solutions Inc.

Roche Point of Care

Org ID: _____ CPS Account #: _____

PHYSICIAN ORDER FOR PT/INR PATIENT SELF-TESTING

COMPLETE ALL SECTIONS. TO AVOID DELAY IN PROCESSING, COMPLETION OF FIELDS WITH (*) ARE REQUIRED
- **Sign and date form**
- **Fax the completed form to CoaguChek® Patient Services (see below)**

1

PATIENT FIRST NAME*	MI	LAST NAME*	LEGAL GENDER ○ M ○ F	DOB (mm/dd/yyyy)*
HOME ADDRESS*		CITY*	STATE*	ZIP/POSTAL CODE*
PRIMARY PHONE # 1-	SECONDARY PHONE # 1-		PATIENT EMAIL (if available)	
MRN # (Medical record number, if applicable for EHR connectivity)				

2 PATIENT DIAGNOSIS CODE* (COMPLETE ALL THAT APPLY)

Based on diagnosis of the patient's condition, enter all the applicable ICD-10 diagnosis codes. Below are commonly used ICD-10 diagnosis codes for patients who are monitoring PT/INR at home. This is not a complete list of possible codes. You may also enter separate code(s) in **Other**. For a full list of ICD-10 codes recognized by CMS, please visit **https://www.cms.gov**

- ○ **Z79.01** - Long term (current) use of anticoagulants
- ○ **I48.11** - Longstanding persistent atrial fibrillation
- ○ **I48.21** - Permanent atrial fibrillation
- ○ **I48.0** - Paroxysmal atrial fibrillation
- ○ **Z95.2** - Presence of prosthetic heart valve
- ○ **I26.99** - Other pulmonary embolism without acute cor pulmonale
- ○ **D68.59** - Other primary thrombophilia
- ○ **Other** - _____

3 THERAPEUTIC RANGE

LOW:* _____

HIGH:* _____

4 NOTIFICATION RANGE

INR results that are <1.8 and >4.5 will be called unless otherwise specified below.

BELOW: _____ ABOVE: _____

5 PRESCRIBED FREQUENCY

Tests per month (select one)*

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

○ **2-4** ○ **Weekly**

NOTE: ***Medicare will cover up to one test per week***

6 PATIENT RESULTS CONTACT

CONTACT FOR PATIENT RESULTS	TITLE	PHONE (OUT OF RANGE)* 1-	FAX (ALL RESULTS)* 1-	CONTACT EMAIL
PRACTICE/CLINIC NAME				
CLINIC STREET ADDRESS*	SUITE #	CLINIC CITY*	CLINIC STATE*	CLINIC ZIP*

7 PATIENT TRAINING *FACE-TO-FACE TRAINING IS REQUIRED**

NOTE: ***CoaguChek Patient Services will train your patient unless one of the options to the right is selected.***

- ○ **By Clinic/Practice (Training contract with CPS must be in place)**
- ○ **Physician certifies patient was face-to-face trained on the CoaguChek PT/INR monitoring system**

8 PHYSICIAN AUTHORIZATION (SIGNATURE AND DATE MUST BE HAND-WRITTEN OR E-SIGNED)

This form serves as a Physician's Order for the CoaguChek PT/INR monitoring 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.

SIGN & DATE **PRESCRIBING PHYSICIAN SIGNATURE***		DATE (mm/dd/yyyy)*	PHYSICIAN NPI*
PRESCRIBING PHYSICIAN PRINTED*	PHYSICIAN PRIMARY PHONE # 1-		PHYSICIAN FAX# 1-

NOTE: ***If Physician Primary Phone/Fax is left blank, the contact information in Section 6 (Patient Results Contact) will be used for contacting physician as needed.***

9 INSURANCE INFORMATION ○ No Insurance Coverage TO EXPEDITE PATIENT ENROLLMENT PLEASE INCLUDE A COPY OF FRONT AND BACK OF PATIENT'S INSURANCE CARD

PRIMARY HEALTH INSURANCE INFORMATION	INSURANCE COMPANY	POLICY ID#	CUSTOMER SERVICE PHONE # 1-
SECONDARY HEALTH INSURANCE INFORMATION	INSURANCE COMPANY	POLICY ID#	CUSTOMER SERVICE PHONE # 1-

PLEASE FAX COMPLETED FORM TO THE CENTRAL OFFICE§ 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

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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) Based on diagnosis of the patient's condition, enter all the applicable ICD-10 diagnosis codes. Below are commonly used ICD-10 diagnosis codes for patients who are monitoring PT/INR at home. This is not a complete list of possible codes. You may also enter separate code(s) in Other. The website below has more information about ICD-10 codes recognized by CMS under the National Coverage Determination for PT/INR testing (NCD 190.11) available as one of 26 files: https://www.cms.gov

CODE	DESCRIPTION
Z79.01	Long term (current) use of anticoagulants
I48.11	Longstanding persistent Atrial fibrillation
I48.21	Permanent Atrial fibrillation
I48.0	Paroxysmal atrial fibrillation
I26.99	Other pulmonary embolism without acute cor pulmonale
Z95.2	Presence of prosthetic heart valve
D68.59	Other primary thrombophilia

Medical Information

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

(4) A standard notification range has been established for calls to your clinic unless otherwise specified.

(5) **Prescribed Frequency**, or Tests per Month offered by CoaguChek Patient Services are: **2-4/month or weekly**

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

(6) **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. To request access to CoaguChek Link, please call 1-800-780-0675. All results are faxed to your office unless requested to CPS.

Patient Training

(7) 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 (Default option)

C) If patient has been previously trained on use of CoaguChek PT/INR monitoring system, physician may certify that patient received face-to-face training.

Physician Authorization

(8) Prescribing Physician's signature and date signed, enter Physician NPI #, Printed Physician Name, Physician's Primary Phone, and Fax. Note: If Physician Primary Phone/Fax is left blank, the contact information in Section 6 (Patient Results Contact) will be used for contacting physician as needed.

Insurance Information

(9) 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 send 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,
9115 Hague Rd, Indianapolis, IN 46256

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