





Streamlined Process for Providers to Confirm Patient Diagnosis and Treatment Plan

An Overview & Process Guide

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STREAMLINED PROCESS FOR PROVIDERS TO CONFIRM PATIENT DIAGNOSIS AND TREATMENT PLAN

 Patient Advocate Foundation Co-Pay Relief Program (CPR) is excited to announce we have enhanced the process of verifying the patient's diagnosis and treatment plan!

 Our goal is to reduce the burden of verifying the patient's diagnosis by enabling providers, including authorized staff members, to verify the patient's diagnosis during the application process.

This new process is effective for all applications submitted on or after June 14, 2019.

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As an alternative to submitting the Physician Form that has historically been required by the program, the patient's diagnosis and treatment plan can be reported and verified **instantly** by the **provider or authorized staff designee**.

During **Step 6** of the application process the following information will need to be entered and/or verified:

- Information about the treating physician
- Information about the provider and/or authorized staff designee completing the application
- The patient's diagnosis, including name of condition and/or ICD-10 code(s) and stage of disease (as applicable)
- Information about the patient's treatment plan
- Authorized staff designee's attestation confirming the accuracy of the diagnosis and treatment plan information being reported
 - The attestation can be done **verbally** when applying via phone or **electronically signed** when applying via the provider portal
- Authorized staff designee completing the application must have **direct access** to the patient's medical records **and** permission to complete the form on behalf of the treating physician

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Step 6_Section 1: The selected treating physician will automatically pre-populate at the top of the screen will based on the portal registration information.

Step 6_Section 2: Enter the required information for the provider or the authorized staff designee completing the application.

STEP 6: PROVIDE VERIFICATION OF DIAGNOSIS AND TREATMENT PLAN PortalTest765@patientadvocate.org [Logout](#)

SELECTED TREATING PHYSICIANS

First Name	Last Name	Facility/Practice Name	Physical Address	City	State	Zip	Telephone	Fax
MARK	FLEMING	MARK FLEMING	3000 COLISEUM DR	HAMPTON		23666	7578279400	7578279320

INFORMATION OF PERSON COMPLETING FORM:

* First Name	<input type="text"/>	* Last Name	<input type="text"/>
* Facility/Practice Name	<input type="text"/>	* Telephone	<input type="text"/>
* City	<input type="text"/>	* State	<input type="text" value="Select..."/>
* Zip Code	<input type="text"/>	* Position	<input type="text"/>
* Fax	<input type="text"/>	NPI	<input type="text"/>

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Step 6_Section 3: Complete the required Diagnosis and Treatment Information fields.

Helpful Tips:

- When selecting the Primary Diagnosis from the drop-down menu, please use your **down arrow key** and click enter.
- If applying for any metastatic stage cancer fund, please select the **stage** from the Primary Diagnosis drop down menu.
- If the Primary Diagnosis is selected; the ICD-10/Diagnosis Code will automatically populate.
- If the ICD-10/Diagnosis Code is selected; the Primary Diagnosis will automatically populate.

Step 6_Section 4: Enter the list of current medications included in the patient's treatment plan

DIAGNOSIS AND TREATMENT INFORMATION:
Please use your down arrow key and enter when selecting diagnosis.

* Primary Diagnosis * ICD-10/Diagnosis Code

* Date of Diagnosis * Treatment Start Date

TREATMENT MEDICATIONS

+ Add Item Delete

Medication Name	Dosage	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>

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Part 6_Step 5: The provider or authorized staff designee can attest to the accuracy of the diagnosis and treatment plan of the patient based on the medical records maintained by the provider's office. To utilize this instant verification process, select "YES" to the attestation statement and electronically sign the application.

Note: A provider may opt not to utilize the instant verification process to confirm a patient's diagnosis and treatment plan. In this case, select "NO" to the attestation statement and a physician form will be sent to the provider office for completion.

- If **YES** is selected – no additional forms will need to be submitted

* I attest that I have permission to complete this form on behalf of the treating physician and the information provided is complete and accurately describes the patient's diagnosis based on the patient's medical records. Yes No

- If **No** is selected – a completed physician form will be required

* I attest that I have permission to complete this form on behalf of the treating physician and the information provided is complete and accurately describes the patient's diagnosis based on the patient's medical records. Yes No

If No, you will be faxed a standardized Physician Form to complete and return to PAF Co-Pay Relief Program. Failure to complete and return this form within 30 days will result in the patient's award being rescinded.

- Once a "YES" OR "NO" selection is made, click "next" to review the agreement terms and conditions then electronically sign and submit the application.

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Step 6_Sections 1-5 Summary: The application process allows the provider or authorized staff designee to provide verification of the patient's diagnosis and treatment plan.

- 1. ✓ Patient Information
- 2. ✓ Financial Information
- 3. ✓ Authorized Contacts
- 4. ✓ Insurance Information
- 5. ✓ Physician Information
- 6. Diagnosis & Treatment
- 7. Patient Attestations

STEP 6: PROVIDE VERIFICATION OF DIAGNOSIS AND TREATMENT PLAN

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SELECTED TREATING PHYSICIANS

First Name	Last Name	Facility/Practice Name	Physical Address	City	State	Zip	Telephone	Fax
MARK	FLEMING	MARK FLEMING	3000 COLISEUM DR	HAMPTON		23666	7578279400	7578279320

INFORMATION OF PERSON COMPLETING FORM:

* First Name	<input type="text"/>	* Last Name	<input type="text"/>
* Facility/Practice Name	<input type="text"/>	* Telephone	<input type="text"/>
* City	<input type="text"/>	* State	Select... <input type="button" value="v"/>
* Zip Code	<input type="text"/>	* Position	<input type="text"/>
* Fax	<input type="text"/>	NPI	<input type="text"/>

DIAGNOSIS AND TREATMENT INFORMATION:

Please use your down arrow key and enter when selecting diagnosis.

* Primary Diagnosis	<input type="text"/>	* ICD-10/Diagnosis Code	<input type="text"/>
* Date of Diagnosis	<input type="text"/>	* Treatment Start Date	<input type="text"/>

TREATMENT MEDICATIONS

+ Add Item Delete

Medication Name	Dosage	Frequency
<input type="text"/>	<input type="text"/>	<input type="text"/>

* I attest that I have permission to complete this form on behalf of the treating physician and the information provided is complete and accurately describes the patient's diagnosis based on the patient's medical records. Yes No

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Important Reminders:

- The information submitted to verify the patient's diagnosis will be reviewed by our staff to ensure compliance with program guidelines. **If additional information is needed, our staff will contact the provider or the authorized provider designee directly.**
- If the **provider or the authorized provider designees does not attest** to the patient's diagnosis and treatment plan during the application process, acceptable documentation verifying the patient's diagnosis must be submitted by the provider within 30 days of the creation of the application, or the patient's award will be rescinded.
- This process change is applicable to new and/or renewal application **initiated on or after** June 14, 2019. Any applications submitted prior to this date **must have a signed physician diagnosis verification form on file**
- For personal assistance with the application process, please call us toll free at 866-512-3861.



Patient Advocate Foundation
CO-PAY RELIEF SM

DISPENSING HELP, DELIVERING HOPE

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