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.

Save space for office use only.
Will not print.

***CoaguChek*® Patient Services**
Provided by Roche Health Solutions Inc.

www.coaguchekpatientservices.com • www.TestYourINR.com

dms_mr_001FM1 (DMS-1545) 573-52292-0313

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

CoaguChek Patient Services
11800 Exit 5 Parkway, Suite 122
Fishers, IN 46037

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.