Alere Home Monitoring, Inc.
6465 National Drive
Livermore, CA 94550
1-877-262-4669 Office

PATIENT INFORMATION FORM

Home INR Monitoring

Questions? Call **1-877-262-4669** Option 1

Patient Information – Home INR Monitoring

INSTRUCTIONS

❶ **Complete Patient Information**

❷ **Complete Primary Insurance Information**
- Attach a photocopy of your insurance card (front and back)

❸ **Complete Secondary Insurance Information (if applicable)**
- Attach a photocopy of your secondary insurance card (front and back)

❹ **Sign and Date Release of Information and Assignment of Benefits**

For fastest service, fax all forms to:
Alere Home Monitoring, Inc. at
1-925-606-6978

Or send to:
Alere Home Monitoring, Inc. – New Customers
6465 National Drive, Livermore, CA 94550

PLEASE FILL IN ALL ITEMS COMPLETELY & PLEASE PRINT CLEARLY

❶

PATIENT NAME: (Last Name, First Name, Middle Initial)	**DATE OF BIRTH:** (mm/dd/yyyy) / /	**GENDER:** ☐ Female ☐ Male
MAILING ADDRESS: (Street)	**PATIENT SOCIAL SECURITY #:**	
CITY:	**STATE:**	**ZIP CODE:**
HOME PHONE: ( )	**CELL PHONE:** ( )	
E-MAIL:	**ALTERNATE CONTACT PERSON:**	
PHYSICIAN'S NAME:	**PHYSICIAN'S OFFICE PHONE:** ( )	

❷

PRIMARY INSURANCE:	**SUBSCRIBER NUMBER:**	**GROUP NUMBER:**	
NAME OF INSURED: (If different from patient above)	**NAME OF EMPLOYER:**	**POLICY#:**	
MAILING ADDRESS: (Street)	**CITY:**	**STATE:**	**ZIP CODE:**
PHONE: ( )	**FAX:** ( )		

❸

SECONDARY INSURANCE:	**SUBSCRIBER NUMBER:**	**GROUP NUMBER:**	
MAILING ADDRESS: (Street)	**CITY:**	**STATE:**	**ZIP CODE:**
PHONE: ( )	**FAX:** ( )		

❹

RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary to verify benefits, process claims, or provide appropriate care or related services provided by Alere Home Monitoring, Inc. or its Agents. I acknowledge the receipt of the Privacy Practices for Alere Home Monitoring, Inc.

ASSIGNMENT OF BENEFITS: I authorize Medicare and/or any other insurance plans under which I am covered to make payment to Alere Home Monitoring, Inc. or its Assignee of authorized benefits on my behalf, for products or services furnished to me. I understand that by signing this agreement, I accept financial responsibility for the deductible, co-insurance, and all non-covered charges.

PATIENT'S SIGNATURE:	**DATE:** (mm/dd/yyyy)

A/C#: _____

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HOME INR MONITORING PHYSICIAN FORM

☐ Roche CoaguChek® XS ☐ Alere INRatio®2 ☐ ITC ProTime®

FAX COMPLETED FORM TO **1-925-606-6978** OR **1-925-265-0205**

☐ **See Standing Protocols** ☐ New Prescription ☐ Prescription Renewal ☐ Change Physician ☐ Supplies Only

1. PATIENT & PHYSICIAN INFORMATION

PATIENT NAME: (Last Name, First Name, Middle Initial)		**DATE OF BIRTH:** (mm/dd/yyyy) / /	**GENDER:** ☐ Female ☐ Male
PATIENT PHONE #: ( )	**PATIENT SECONDARY #:** ( )	**ADDITIONAL PATIENT CONTACT INFORMATION:**	
PRESCRIBING PHYSICIAN:		**LICENSE #:**	**NPI #:**
GROUP PRACTICE OR HOSPITAL NAME:		**OFFICE PHONE:** ( )	**OFFICE FAX:** ( )
MAILING ADDRESS: (Street)		**CITY:**	**STATE:** / **ZIP:**
REPORT RESULTS TO: (Only if different from above)		**CONTACT PHONE:** ( )	**CONTACT FAX:** ( )

AFTER HOURS CONTACT INSTRUCTIONS:

2. STATEMENT of MEDICAL NECESSITY / PRESCRIPTION

This form serves as a letter of medical necessity and order for Home INR Monitoring equipment, supplies, and related services. Alere Home Monitoring, Inc. will perform all necessary services; equipment and supplies may be provided by either **Alere** or its third party vendor, Edgepark Medical Supplies. Patient should receive Home INR Monitoring services to enable him/her to self-test according to my instructions provided below (section 4). I certify that it is medically necessary for the patient to self-test frequently in order to maintain a stable INR, optimize its therapeutic effects and avoid the complications identified on warfarin's product labeling. I further certify that the patient's medical record contains supporting documentation to substantiate this medical need.

I certify that this **patient has been on warfarin therapy for >90 days** and will undergo a training program utilizing the Alere Face-2-Face® training protocols to ensure that he/she is capable of self-testing; the patient will be encouraged to test weekly for one month after training to maintain proficiency in self-testing. At this time, the patient or their caregiver has no condition that makes self-testing unsafe (e.g. cognitive disorders). I agree to notify Alere if the patient or their caregiver develops a condition that makes self-testing unsafe. A copy of this order will be retained as part of the patient's medical record.

PATIENT'S DIAGNOSIS:	ICD-9-CM CODE:	COMPLICATIONS:	COMORBIDITIES:
WARFARIN START DATE: ____/____/____		☐ Long term Anticoagulant Use	☐ Diabetes
☐ Heart valve; organ or tissue replaced by other means	V43.3	☐ Potential drug/dietary interactions	☐ CHF
☐ Atrial fibrillation (established, paroxysmal)	427.31	☐ Venipuncture difficulty	☐ COPD
☐ Venous embolism & thrombosis (DVT)	453.40	☐ History TIA/Stroke	☐ Thyroid Disorder
☐ Venous embolism & thrombosis (Other)	453.9	☐ History of unstable INR	☐ Hypertension
☐ Phlebitis & thrombophlebitis	451.9	☐ History of major bleeding	☐ Other:
☐ Pulmonary embolism & infarction	415.19	☐ Other: ____	____
☐ Primary hypercoagulable state	289.81	____	____
☐ Other: ____	____	☐ Recent Hospitalizations: ____/____/____	____

3. TARGET INR RANGE & TEST FREQUENCY

TARGET INR RANGE: ____ (LOW) **TO** ____ (HIGH)

TEST FREQUENCY: ☐ 2-4 times/month ☐ Weekly*

*Medicare will cover up to 52 tests per year.

DURATION: Patient shall continue Home INR Monitoring as prescribed for as long as he/she remains capable and compliant with my instructions (indicated below), but in no case for less than one year, unless otherwise noted. ☐ Other: ____

4. TEST REPORTING INSTRUCTIONS

Direct to Alere™ Home Monitoring

Patient will communicate INR test results directly to Alere, who will report results to me according to my instructions below.

For In Range Results

Check one.

☐ Fax ALL results upon receipt

OR

☐ Only fax monthly report on the ____ day of the month

AND

For Out of Range Results

Check all that apply.

Fax Report	Call my Office	
☐	☐	ALL results
☐	☐	Results with an alert value of: Low: < ____ High: > ____
☐	☐	Other: ____

☐ In addition, instruct patient to retest within ____ days.

OR

Direct to Physician Office

☐ Patient will communicate INR test results directly to my office each time they test.

☐ Other: ____

Patient will also provide Alere with all past INR test results at least once a month to ensure ongoing test supplies. Physician accepts full responsibility for ongoing communication of patient generated INR test results.

NOTE: Documenting home INR test results is required by Medicare and some other payors in order for Patient's testing supplies to be covered. Alere will provide a report of past results as a courtesy to support Physician claims for Review and Interpretation of home INR tests (G0250).

If Patient reports an INR value <1.5 or >5.0, then Alere will make direct contact with your office and fax the patient summary report. If Alere is unable to communicate with a qualified individual from your office, then Alere will recommend to your Patient to seek immediate emergency care.

ITEMS PRESCRIBED: One (1) Home INR Monitoring System (see preferred brand at top of form), and related testing materials (i.e. Test Strips, Lancets, and other supplies required). Testing materials will be provided in increments of 12.

PHYSICIAN'S SIGNATURE: (In compliance with CMS Pub. 100-08, Transmittal 327, Section 6698.3. Stamped signatures are not acceptable)	**DATE:** (mm/dd/yyyy)	**Does patient have a training preference?**
NO SIGNATURE STAMPS		☐ No ☐ Yes ____

A/C#: ____

 PN: 700207-04 01/12