Medical Care Provider Statement

Accessia Health requires that the applicant's medical care provider supply the information below in order to process the applicant's request for financial assistance. It can be submitted to Accessia Health via secure portal upload, email assistance@accessiahealth.org , fax 804-744-9388, or mail.

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 has been diagnosed with the condition listed above.
- The patient's diagnosis and treatment were determined independently by me or in conjunction with another medical care provider based on the clinical best interest of the patient. The diagnosis was performed prior to any communications with Accessia Health 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: _____