BioTel HEART

Remote INR™ Enrollment Guide

Four easy steps to enrolling patients in Remote INR

1 The healthcare professional provides patient information

The healthcare professional submits the Physician Order Form and Patient Insurance Data online at RemoteINR.com or by fax.

2 Remote INR verifies insurance coverage

Remote INR will contact your insurance provider, review coverage, obtain authorization if needed, and receive and estimate out-of-pocket cost.

3 Remote INR 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 Remote INR schedules patient training

Patients can be trained in the clinic by the patient's physician office, virtually 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 RemoteINR.com

Remote INR™
by BioTel Heart
formerly CoaguChek® Patient Services

Instructions for completing patient enrollment for PT/INR Monitoring with Remote INR

For easy, on-line patient enrollment, go to RemoteINR.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: http://go.cms.gov/2D7EvGU

CODE	DESCRIPTION
Z79.01	Long term (current) use of anticoagulants
I48.2	Chronic 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
D68.51	Activated protein C resistance
Z95.4	Presence of other heart-valve replacement

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 Remote INR 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 Remote INR.com, please call 1-800-780-0675. All results are faxed to your office unless requested to Remote INR.

Patient Training

⑦ Please indicate **one** of the following patient training option:

A) By Clinic/Practice **(Practice must complete certification training and agreement)**

B) By Remote INRs

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, Clinic/Practice address, Physician's Primary Phone, Fax and e-mail address.

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

– Remote INR will mail the Authorization Form to patient for signature if it is not submitted with the Physician Order.

☐ Fax forms to Remote INR at **1-800-779-8560**. Or mail forms to:
Remote INR
1000 Cedar Hollow Road, Malvern, PA 19355

If you have any questions, please contact Remote INR at **1-800-780-0675**.

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PATIENT INFORMATION

PATIENT FIRST NAME	MI	PATIENT 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)	
DATE TRAINED (MM/DD/YYYY)	○ PHYSICIAN'S OFFICE	○ IN HOME	○ VIRTUALLY	

PATIENT ACKNOWLEDGEMENT FORM

I acknowledge the following:

- ☐ I have been thoroughly trained and understand how to operate the device and read the results of the tests that I will be performing.
- ☐ I understand the four options available to report my results.
- ☐ I understand for any meter problems to contact Roche at 1-800-428-4674.
- ☐ I understand for questions regarding supplies, reporting results or my service to contact Remote INR at 1-800-780-0675.
- ☐ I will test as prescribed by my physician: ____________
- ☐ I understand that the INR monitoring equipment I receive is solely the property of BioTel Heart and I will return the meter to BioTel Heart if:
  - I discontinue participating in this program; or
  - I do not comply with my doctor's orders.
- ☐ I understand that I am financially responsible for any loss or damage to the INR monitoring equipment while it is in my possession.
  - **Loss or damage to the INR meter, replaceement cost: $900.**

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by BioTel Heart
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Mail or fax completed for to:
Remote INR
1000 Cedar Hollow Road | Malvern, PA 19355
Phone: 1-800-780-0675 | Fax: 1-800-779-6207
www.RemoteINR.com

BioTel® HEART

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ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

Remote INR provided by BioTel INR, LLC 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 request that payment of authorized health insurance benefits, including Medicare benefits, if I am a Medicare beneficiary, to be made on my behalf to BioTel INR, LLC, a subsidiary of BioTelemetry, Inc. (“BioTel INR”) for any medical services provided to me by BioTel INR. I authorize any holder of medical and/or insurance information about me to release to BioTel INR, my health insurance carrier, or the Centers for Medicare and Medicaid Services (CMS) any information needed to determine these benefits or the benefits payable for related services provided under this agreement. This assignment includes all dates of services rendered by BioTel INR for all insurance plans. A copy of this authorization will be sent to CMS or my health insurance carrier if requested. The original will be kept on file by BioTel INR.

I understand that I am fully responsible to BioTel INR for any co-payments, co-insurance, deductibles, payments made directly to me by my health insurance carrier for BioTel INR services, and, when allowed by law, services not-covered or payable under my health insurance plan. I also understand that by signing this form and/or accepting these terms electronically, I am accepting financial responsibility as explained above for all payment for services received from BioTel INR.

By accepting these terms electronically or by usage of the service, I acknowledge that I have received a copy of BioTelemetry’s Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

CONFIDENTIALITY AND NOTICE OF PRIVACY PRACTICES

Available in the Patient Handbook or
online at gobio.com\privacy

SIGNATURE REQUIRED	
PATIENT SIGNATURE SIGN	DATE (MM/DD/YYYY)
PATIENT NAME (printed)	DATE (MM/DD/YYYY)
INR TRAINING VALUE	DEVICE SERIAL NUMBER

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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 Remote INR (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: Remote INR will train your patient unless one of the options to the right is selected.

- ○ **By Clinic/Practice (Training contract with Remote INR 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 Remote INR 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: FAX: 1-800-779-8560

For questions call: 1-800-780-0675

RemoteINR.com
1000 Cedar Hollow Road, Malvern, PA 19355 | gobio.com

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