Genentech® Access to Care Foundation (GATCF)
Insurance Attestation – HCP Administered Drugs

Phone (866) 681-3329 - Fax (866) 681-3338

This form is required for each of your patient's insurances and will serve as proof that the patient's insurance company will not cover the prescribed ACTEMRA® (tocilizumab) therapy. This form should be completed once you have the outcome of the first level of appeal.

Check ALL box(es) that apply to your patient and fax to GATCF at the number listed above.

❑ My office received a first-level appeal denial and the initial claim or Prior Authorization (PA) denial is upheld.

Date of initial claim or PA denial: _____/_____/_____

Reason for initial claim or PA denial:_____

Date of first-level appeal denial: _____/_____/_____

Reason for first-level appeal denial:_____

❑ My office received a recoupment for date of service:_____/_____/_____

Date of recoupment letter:_____/_____/_____

Reason for recoupment:_____

❑ My office received a peer-to-peer denial.

Date of review:____/___/____

Reason denial:_____

❑ My patient has met the daily/yearly CAP for insurance coverage.

Date CAP was met:_____/_____/_____

Date CAP reset:_____/_____/_____

PLEASE NOTE: If the patient's insurance denied coverage due to an administrative error, untimely filing or not following the insurance policy requirements, your patient does not meet GATCF insurance criteria. GATCF requires one level of appeal for patients to be considered rendered uninsured.

Please complete, sign and date the following statement. (REQUIRED)

Authorized HCP Signature (Required): _____Date:_____

Print Physician First and Last Name: _____

Patient Insurance Company Name: _____

Print Patient's First and Last Name: _____

Patient's Date of Birth: _____

CERTIFICATION: By signing above, I certify this form is an accurate representation of my patient's insurance status and his/her insurance company's refusal to cover the prescribed therapy. I understand the information provided will be used in accordance with GATCF eligibility requirements.

I know GATCF could ask me for a copy of the patient's insurance denial/appeal records for the purpose of an audit. I agree to provide a copy of the patient's denial/appeal records in a timely manner, if so requested. Please note, GATCF will pursue all appropriate legal remedies, including seeking damages in litigation, in the event GATCF determines this certification is false or the Insurance Attestation is false or inaccurate.

Only the information requested on this form is required.
Providing additional documents or information will delay processing.

*The overseeing physician is accountable for the individual signing on the physician's behalf of the Health Care Professional (HCP).

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