



## PATIENT PORTAL USER GUIDE



## Co-Pay Relief (CPR) Online Portal

PAF is a pioneer in providing charitable patient assistance, and we feel that our Co-Pay Relief Program has a responsibility to continually evolve to ensure that our operations are both efficient and effective.

Our goal with the patient, provider and pharmacy portals is to deliver an online experience that is resourceful, provides actionable information to you based on your needs and is in a format that is customizable and takes less of your valuable time to use!

## What Do You Need to Do Now?

Existing individual users simply Login using your current username (email address) and password.

If this is your first time using the online portal, you will be required to register.



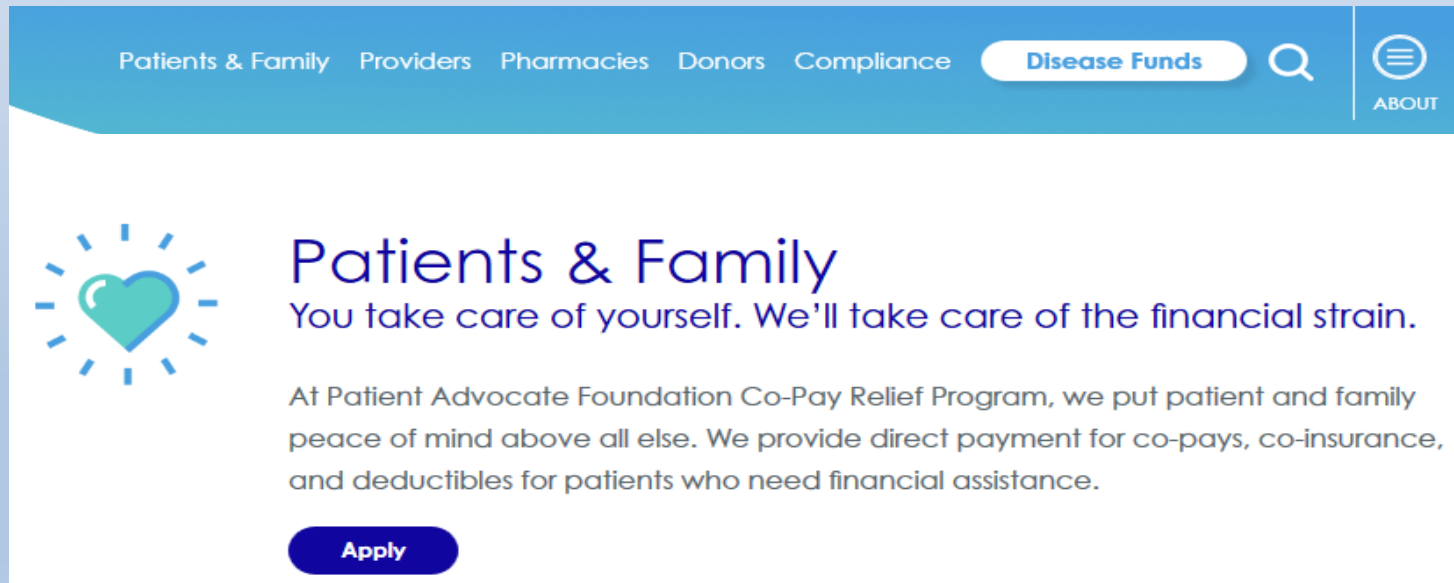
## CO-PAY RELIEF PROGRAM PATIENT PORTAL

# NEW REGISTRATION FOR PATIENT PORTAL

## Step 1: Register as a Portal User

- ▶ Visit <http://www.copays.org/>
- ▶ There are several entry points to access the online portal!
  - The Home screen
  - The Patients & Family tab
  - Select your disease from the **Find Your Fund List**
- ▶ Select **Apply**

*The example below displays the **Apply** button from the Patients & Family tab*

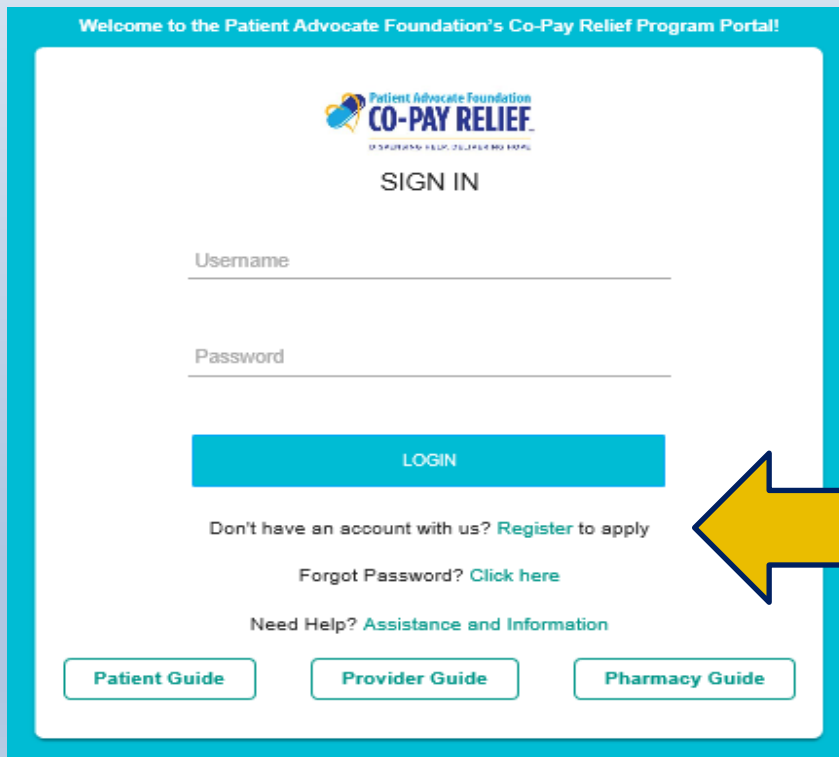


The screenshot shows the top navigation bar of the Patient Advocate Foundation website. The navigation menu includes: Patients & Family, Providers, Pharmacies, Donors, Compliance, Disease Funds (highlighted in a blue pill), a search icon, and an ABOUT link with a hamburger menu icon. Below the navigation bar, the 'Patients & Family' section is displayed. It features a teal heart icon with radiating lines on the left. The main heading is 'Patients & Family' in a large, dark blue font. Below the heading is the tagline: 'You take care of yourself. We'll take care of the financial strain.' A paragraph of text follows: 'At Patient Advocate Foundation Co-Pay Relief Program, we put patient and family peace of mind above all else. We provide direct payment for co-pays, co-insurance, and deductibles for patients who need financial assistance.' At the bottom of this section is a dark blue button with the word 'Apply' in white text.


# NEW REGISTRATION FOR PATIENT PORTAL

If you are a first-time user, you will be required to register prior to starting the application process.

*Note: If you are already a registered user you do not need to register again, For Sign IN Instructions and next steps, proceed to page 14.*



Welcome to the Patient Advocate Foundation's Co-Pay Relief Program Portal!

  
DISBURSING HELP DELIVERED HOME

SIGN IN

Username \_\_\_\_\_

Password \_\_\_\_\_

[LOGIN](#)

Don't have an account with us? [Register to apply](#)

Forgot Password? [Click here](#)

Need Help? [Assistance and Information](#)

[Patient Guide](#) [Provider Guide](#) [Pharmacy Guide](#)



# NEW REGISTRATION FOR PATIENT PORTAL

## Registration: Welcome Screen

Who Are You: Select **Patient Registration** and click **Next** to proceed

**WELCOME TO PAF CO-PAY RELIEF REGISTRATION!**

WHO ARE YOU? BASIC INFO CONTACT INFO

Please select the type of user you are to proceed

**PATIENT REGISTRATION**

PROVIDER REGISTRATION

PHARMACY REGISTRATION

Need Help? [Assistance and Information](#)

Already a registered user? [Click here to login](#)

**NEXT**

## Registration: Welcome Screen (*continued*)

**Basic Information-** Complete the following required fields, then select **Next**

### WELCOME TO PAF CO-PAY RELIEF REGISTRATION!

WHO ARE YOU?    **BASIC INFO**    CONTACT INFO

Provide patient basic information to validate their identity and check their eligibility

<b>Patient First Name</b> Karen	<b>Patient Last Name</b> Carls	<b>Patient DOB</b> 02/01/1950
<b>Email</b> karenca@hotmail.com	<b>SSN or Alien No</b> 125-93-2615	

**CANCEL**    **NEXT**

### QUICK TIPS

1. Format for Patient DOB  
MM/DD/YYYY
2. Format for Alien Number  
A1234567



# NEW REGISTRATION FOR PATIENT PORTAL

## Registration: Welcome Screen (*continued*)

**Contact Information-** Complete the following required address fields, then select **Verify Address**. If “Address Verified” appears, select **Register!**

WELCOME TO PATIENT ADVOCATE FOUNDATION'S CO-PAY RELIEF REGISTRATION!

WHO ARE YOU? BASIC INFO CONTACT INFO

Provide the patient contact information for further communications

Phone: 7578512200

Address Line 1: 1118 Big Bethel Rd

Address Line 2: \_\_\_\_\_

City: Hampton

State: Virginia

ZIP Code: 23666

Address Verified.

VERIFY ADDRESS

CANCEL REGISTER

**QUICK TIPS**

1. Format for Patient DOB  
MM/DDYY
2. Format for Alien Number  
A1234567

# NEW REGISTRATION FOR PATIENT PORTAL

## Registration: Welcome Screen (*continued*)

**Contact Information** - If the system is unable to verify the address entered, please review and make necessary correction. If the address provided is correct, select **Register**!

**WELCOME TO PATIENT ADVOCATE FOUNDATION'S CO-PAY RELIEF REGISTRATION!**

WHO ARE YOU?      BASIC INFO      **CONTACT INFO**

Provide the patient contact information for further communications

Phone: 7578512200      Address Line 1: 1150 Bethel Rd      Address Line 2: \_\_\_\_\_

City: Hampton      State: Virginia       ZIP Code: 23666

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

**VERIFY ADDRESS**

**CANCEL**      **REGISTER**

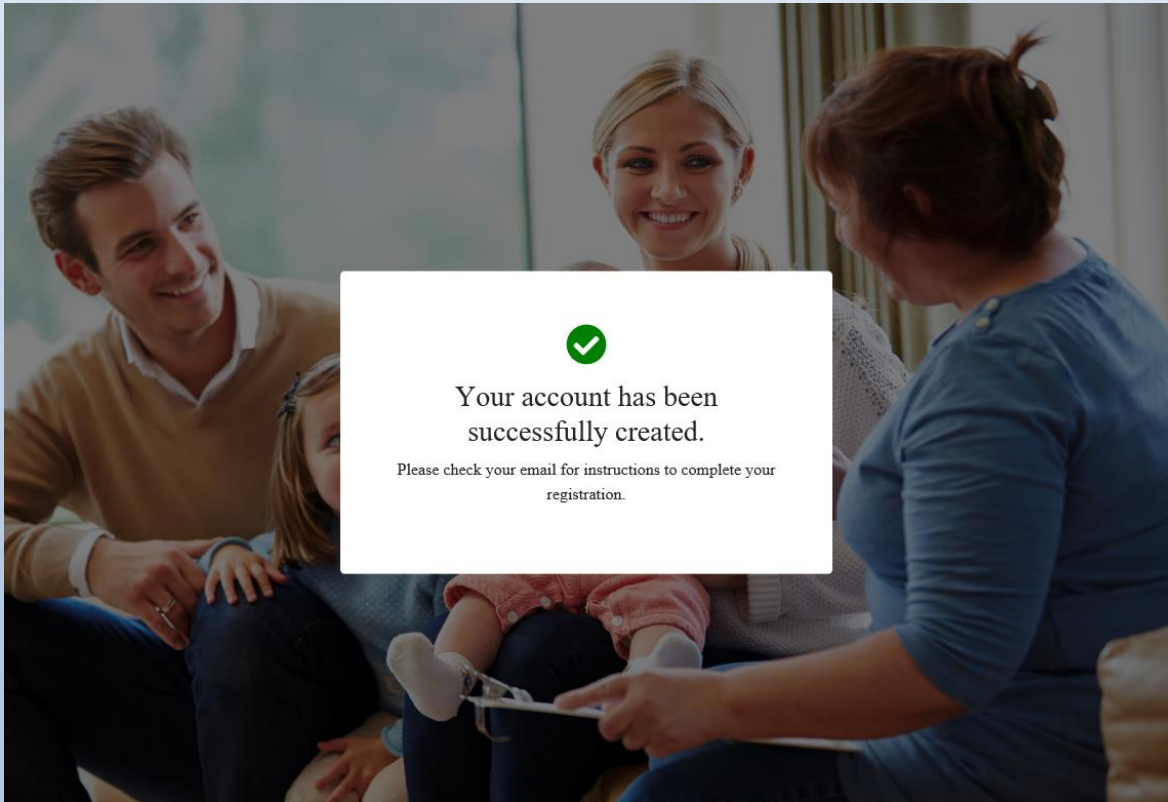
**QUICK TIPS**

1. Format for Patient DOBMM/DDY
2. Format for Alien Number A1234567

# NEW REGISTRATION FOR PATIENT PORTAL

## Registration (continued)

**Successful Submission:** Upon successful registration, you will receive an email with instructions to create a password.



### QUICK TIP

If you do not receive an email confirmation, please check your spam/junk mail.

# NEW REGISTRATION FOR PATIENT PORTAL

## Registration (continued)

Once you receive your email confirmation, click **Confirm Password**.

Dear Program User,

Thank you for registering to use Patient Advocate Foundation's Co-Pay Relief Program (CPR) online Patient Portal. The portal offers you many features and is available 24/7, allowing you to interact with the CPR program whenever it is most convenient for you. Now that you have established a secure portal account, you can utilize it to complete your applications for assistance from the program. As well, if you are eligible for assistance, you will be able to utilize your portal account to submit patient claims for payment, check the status of your grant, including account balance and expiration dates, and reapply for assistance next year if needed.

Please remember that this site is for the exclusive use of patients in our program. Login credentials should not be shared with anyone.

To confirm your CPR portal account registration, and create a password, please click the link below:

[Confirm Password](#)



If you have any questions about your portal account, or encounter any difficulties, please do not hesitate to contact us at 866-512-3861, [select the option for portal inquires&technical issues. We look forward to serving you.](#)

Regards,

PAF Co-Pay Relief Program Team

## QUICK TIP

**Confirm Your Password  
within 2 hours**

# NEW REGISTRATION FOR PATIENT PORTAL

## Registration (continued)

Enter and confirm your password using the following requirements

Patient Portal

Welcome to the PAF Co-Pay Relief Program online application process. Below you will see patients submitted through the online portal.

**Password Requirements**


Cannot contain the user's account name	-English uppercase characters(A-Z)
Must be at least eight characters in length	-English lowercase characters(a-z)
Contain characters from three of the following four categories:	-Numeric digit(0 through 9)
	-Non-alphabetic characters(for example:!,\$,#,%...)

Confirm Password

Password  
.....

Confirm Password  
.....

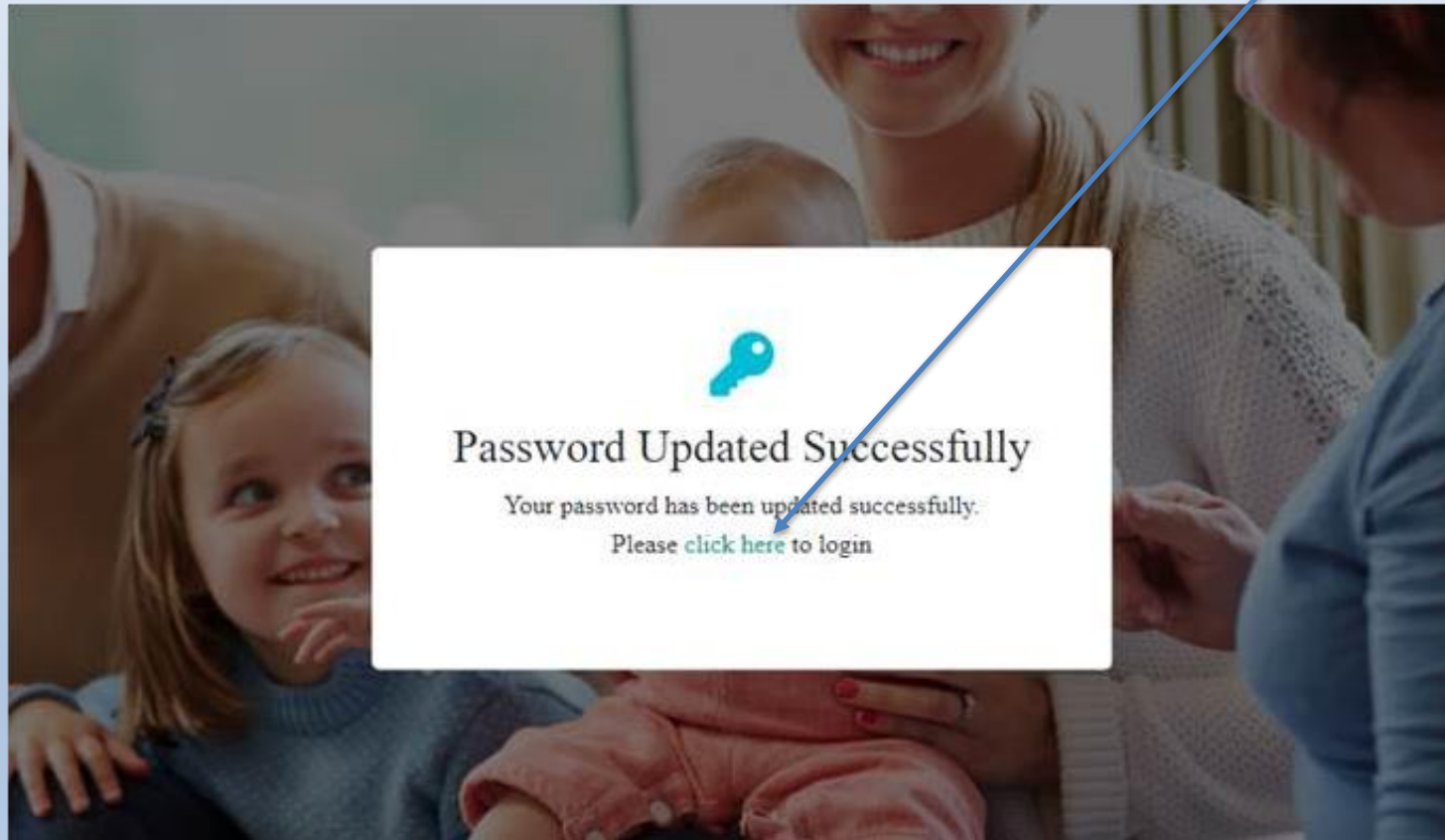
**UPDATE PASSWORD**



# NEW REGISTRATION FOR PATIENT PORTAL

## Registration (continued)

Once you have successfully created a password, please select **Click Here** to sign into the portal




# SIGN IN ON PATIENT PORTAL

## Existing User Login

For existing users, sign in with your username (email address) and password, then select **Log In**.

Welcome to the Patient Advocate Foundation Co-Pay Relief Program Portal!



SIGN IN

Username \_\_\_\_\_

Password \_\_\_\_\_

**LOGIN**

Don't have an account with us? [Register](#) to apply

Forgot Password? [Click here](#)

Need Help? [Assistance and Information](#)



# CREATE NEW APPLICATION PATIENT PORTAL

Welcome to the Patient Dashboard!

To begin a new application, select **+Create Application**

**Patient Advocate Foundation**  
**CO-PAY RELIEF**  
www.patientadvocate.org

PatientTest@patient.net [Logout](#)

[Dashboard](#) [Applications](#)

**Patient Dashboard**  
List of all the Action Items

**Recently Created Application**  
No Applications found!  
**+ Create Application**

**Recent Activities**  
No Activities found!

**Actions Required**  
No Actions found!



# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### The Application process consists of 5 sections:

- Patient Information
- Authorized Person(s)
- Insurance Information
- Medical
- Authorization

**CO-PAY RELIEF PROGRAM APPLICATION**

John Simmons | xxx-xx-3856 | 03/26/1954

<b>PATIENT INFORMATION</b>	AUTHORIZED PERSON	INSURANCE	MEDICAL	AUTHORIZATION
----------------------------	-------------------	-----------	---------	---------------

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### Patient Information Tab

- Select Fund Name from drop-down menu. Once the Fund has been selected you will be automatically directed to the Prequalification screen

**COPAY RELIEF PROGRAM APPLICATION**

Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION	AUTHORIZED PERSON	INSURANCE	MEDICAL	AUTHORIZATION
---------------------	-------------------	-----------	---------	---------------

Fund Applying For  
Breast Cancer Silo\*

# CREATE NEW APPLICATION PATIENT PORTAL

## Application

### Patient Information Tab

- Complete the Prequalification questions that will appear based on the fund selected
- Select **Submit**

#### Pre Qualification - Breast Cancer Sil ✕

Does the patient have medical or prescription insurance that covers a portion of their pharmaceutical products being prescribed for their diagnosis?

Is the patient currently in treatment, planning to begin treatment in the next 60 days or have been in treatment in the past 6 months?

Does the patient reside in the U.S. or a U.S. territory?

Family Size

Household Income

zipcode

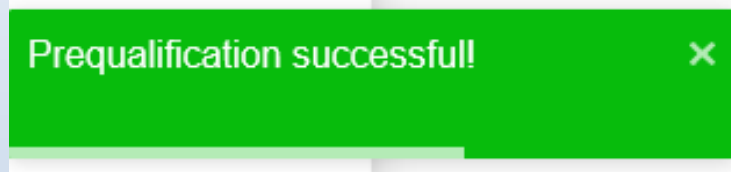


# CREATE NEW APPLICATION PATIENT PORTAL

## Application: Patient Information Tab

### Prequalification questions –Successful

-If Prequalification was successful, continue with the application process



### Prequalification questions –Failed

-If Prequalification was not successful, you will receive a message explaining the reason it was not successful. Please retain this information for your records.

#### *Sample Denial Message*

**Ineligible due to not in treatment**

Based on the information provided, unfortunately you are not eligible for the assistance through the program due to the following reason(s):

All applicants are required to be currently in treatment, planning to begin the treatment in the next 60 days, or have been in treatment in the past six(6) months

If your circumstances change in the future, please feel free to contact the Co-Pay Relief Program at 1-866-512-3861 so that a program specialist can assist you.

# CREATE NEW APPLICATION

## PATIENT PORTAL

Application:

### Patient Information Tab: Address Details

Complete the required address fields, then select **Verify Address**. If “Address Verified” appears, proceed to the next step.

**ADDRESS DETAILS**

<p><b>Address Type</b></p> <p>Home <input type="checkbox"/></p>	<p><b>Address Line 1</b></p> <p>5000 City Line Rd</p>	<p><b>Address Line 2</b></p> <p></p>
<p><b>City</b></p> <p>Hampton</p>	<p><b>State</b></p> <p>VA <input type="checkbox"/></p>	<p><b>ZipCode</b></p> <p>23670</p>

Address Verified.

[VERIFY ADDRESS](#)

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### Patient Information Tab: Address Details

If the system is unable to verify the address entered, please review and make necessary corrections. If the address provided is correct, you may proceed to the next step.

**ADDRESS DETAILS**

<b>Address Type</b> Home <input type="checkbox"/>	<b>Address Line 1</b> 5000 Hampton Rd	<b>Address Line 2</b> 
<b>City</b> Hampton	<b>State</b> VA <input type="checkbox"/>	<b>ZipCode</b> 23670

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### Patient Information Tab: Address Details

If the system identifies a zip code mismatch, the system will prompt you to correct the zip code. Select **YES** and make necessary corrections if needed and proceed to the next step.

A Zip Code mismatch has occurred, would you like to correct the Zip Code? ✕

**YES** **NO**

**ADDRESS DETAILS**

<b>Address Type</b> Home <input type="checkbox"/>	<b>Address Line 1</b> 5000 City Line Rd	<b>Address Line 2</b> 
<b>City</b> Hampton	<b>State</b> Virginia <input type="checkbox"/>	<b>ZipCode</b> 23661

**VERIFY ADDRESS**

# CREATE NEW APPLICATION

## PATIENT PORTAL

Application:

### Patient Information Tab: Address Details

If no corrections need to be made to the zip code, select **NO** and proceed to the next step.

A Zip Code mismatch has occurred, would you like to correct the Zip Code? ✕

**YES** **NO**

**ADDRESS DETAILS**

Address Type	Address Line 1	Address Line 2
Home <input type="checkbox"/>	5000 City Line Rd	
City	State	ZipCode
Hampton	VA <input type="checkbox"/>	23661

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

**VERIFY ADDRESS**



# CREATE NEW APPLICATION PATIENT PORTAL

Application:

Patient Information Tab:

Complete the required fields, then select **NEXT**

**CONTACT DETAILS**

Phone Type  Phone Number  Contact Sequence   
Primary

Email

**ADDITIONAL INFORMATION**

Ethnicity  Gender  Employment Status   
Veteran  Marital Status

How were you referred to PAF's Co-Pay Relief Program?  Program

Do you receive assistance from other Co-Pay Programs?  NO

Do you receive assistance from manufacturer free drug programs?  NO

**NEXT**

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### Authorized Person(s) Tab

-If the patient **does not** wish to authorize someone to speak on their behalf, click **Next** to proceed to the next section

COPAY RELIEF PROGRAM APPLICATION

Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION AUTHORIZED PERSON INSURANCE MEDICAL AUTHORIZATION

Anyone authorized to speak on behalf of the patient?  NO

PREVIOUS NEXT

Application:

Authorized Person Tab (*continued*)

If the patient would like to authorize someone to speak on their behalf:

- Select Yes
- Complete the required fields for each authorized person
- To authorize additional people, click **Add One More**
- Select **Next** to Continue

COPAY RELIEF PROGRAM APPLICATION

Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION AUTHORIZED PERSON INSURANCE MEDICAL AUTHORIZATION

Anyone authorized to speak on behalf of the patient? **YES**

Authorized Person

First Name	Last Name	Relationship
Husband	Test	Family <input checked="" type="checkbox"/>

Phone Number  
4789526383

ADD ONE MORE

PREVIOUS NEXT

# CREATE NEW APPLICATION PATIENT PORTAL

## Application: Insurance Information

Complete all required fields, then select **Next** to continue.

*Note: If the name of your insurance does not appear in the drop-down menu, you may manually input the name in the Primary insurance field*

**COPAY RELIEF PROGRAM APPLICATION**  
Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION   AUTHORIZED PERSON   **INSURANCE**   MEDICAL   AUTHORIZATION

**POLICY DETAILS**

Primary Insurance: BCBS   Plan Type: Medicare-A+B

Policy ID: 52136541   Insurance Type: Medicare

Primary Insurance Telephone No: 8881523666

**SUBSCRIBER DETAILS**

Subscriber Name: Patient Test   Group Number: x15621   Subscriber DOB: 02/02/1954

**INSURANCE INFO**

Does the patient have a medicare supplement?  YES

Does the patient have secondary insurance?  YES

Name Of Insurance Carrier: BCBS

PREVIOUS   NEXT

**QUICK TIP**

1. If the name of your insurance does not appear in the drop-down menu, you may manually input the name in the Primary insurance field
2. If the patient's insurance does not consist of a group number, enter "NA"



### Application: Medical Information

### Treating Physician

### Searching for your Treating Physician:

- Select the state from the drop-down menu, then enter the city
- To improve your search results, enter your treating physician's First and Last name
- Press the **Tab** key on your keyboard to start your search

**COPAY RELIEF PROGRAM APPLICATION**  
Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION    AUTHORIZED PERSON    INSURANCE    **MEDICAL**    AUTHORIZATION

**Search Your Treating Physician**  
Please enter State and City to search for your treating physician.  
Enter additional information to improve your search results.  
Press the Tab Key to start your search.

State: Georgia  City: Macon

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application: Medical Information

### Treating Physician (continued)

If your treating physician appears in the list below, click on the appropriate selection

- Your selection will be highlighted in **blue**
- If you need to make a change in your selection, simply click on the correct physician
- If your treating physician does not appear in the list, you can select the **Click Here to Add** hyperlink to manually enter your treating physician

**COPAY RELIEF PROGRAM APPLICATION**  
Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION    AUTHORIZED PERSON    INSURANCE    **MEDICAL**    AUTHORIZATION

**Search Your Treating Physician**  
Please enter State and City to search for your treating physician.  
Enter additional information to improve your search results.  
Press the Tab Key to start your search.

State: Georgia  City: Macon  First Name: Charles

Last Name: Callender

**Select Your Treating Physician**

The following physicians match your search criteria. Please select your treating physician from the list below by clicking on the appropriate selection. Once you have selected the treating physician it will be highlighted in blue. If you need to make a change in your selection, simply click on the correct physician. If you do not see your treating physician on the list below, [click here to add](#)

First Name <input type="checkbox"/>	Last Name <input type="checkbox"/>	City <input type="checkbox"/>	Primary Address <input type="checkbox"/>	Secondary Address <input type="checkbox"/>
CHARLES	CALLENDER	MACON	1062 FORSYTH ST STE 2E	250 MARTIN LUTHER KING JR BLVD

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application: Medical Information

#### Treating Physician (*continued*)

- If your treating physician does not appear in the list, enter all required fields to add your treating physician and select Verify Address.
- If **Address Verified** appears, proceed to Diagnosis and Treatment Information

Add Your Treating Physician

You can also try to search [Click Here to search](#)

First Name Gary	Last Name Henderson	Address Type Physical <input type="checkbox"/>
Address Line 1 11033 Jefferson Ave	Suite#	City Newport News
State VA <input type="checkbox"/>	ZIP Code 23601	Fax 7578251000
Phone Number 7578252000	Ext	Email
Office Contact Name	Office Contact Email	Address

Address Verified.

VERIFY ADDRESS

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application:

### Medical Information- Adding a new treating physician (continued)

- If the system is unable to verify the address entered, please review and make necessary corrections.
- If the address provided is correct, proceed to the Diagnosis and Treatment Information.

Add Your Treating Physician

You can also try to search [Click Here to search](#)

First Name Gary	Last Name Henderson	Address Type Physical <input type="button" value="v"/>
Address Line 1 110033 Jefferson Ave	Suite#	City Newport News
State VA <input type="button" value="v"/>	ZIP Code 23601	Fax 7578251000
Phone Number 7578252000	Ext	Email
Office Contact Name	Office Contact Email	Address

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

VERIFY ADDRESS



## Application: Medical Information

### Diagnosis

Start typing your diagnosis and select the diagnosis from the drop-down menu then click **Next** to proceed

1

Diagnosis

Patient Diagnosis  
Breast cancer

PREVIOUS

NEXT

# CREATE NEW APPLICATION

## PATIENT PORTAL

### Application: Authorization

Select your relationship to the patient

- Click **View Terms and Conditions** to review the Patient Agreement and Rate the Program's Impact
- Review the Opt-Out Agreement
- Enter your electronic signature and phone number
- Click **Sign and Submit**

### COPAY RELIEF PROGRAM APPLICATION

Patient Test | xxx-xx-2255 | 02/02/1954

PATIENT INFORMATION   AUTHORIZED PERSON   INSURANCE   MEDICAL   **AUTHORIZATION**

Your Relationship to Patient:

Self    Guardian    Pharmacy/Specialty Pharmacy

Family Member    Advocate    Physician/Provider

Terms and Conditions:

The patient/authorized agent must review and agree to the Patient Authorization, Disclosures, and Attestation agreement which gives PAF permission to process your application. To view the Terms and Conditions, click the "View Terms and Conditions" button.

**VIEW TERMS AND CONDITIONS**

Your Contact Information may be used in the future to share printed and/or electronic communications from Patient Advocate Foundation (PAF) and the PAF Co-Pay Relief Program (CPR). If you do not wish to receive information from PAF and CPR, Please uncheck the box

\*\*NOTE: You are not required to participate in the general distribution list in order to use email to correspond about your application

E-Signature (Your Name)   Phone Number

Patient Test   4789526262

**PRINT TERMS AND CONDITIONS**

For a complete copy of the Patient Advocate Foundation's Co-Pay Relief program disclaimer and terms and conditions, Please click [here](#)

**PREVIOUS**   **SIGN AND SUBMIT**

# CREATE NEW APPLICATION PATIENT PORTAL

Applications:

Terms and Conditions and Rate the Program Impact

For Patient Representatives, Caregivers, Pharmacies or Providers: ✕

If you are completing this application on behalf of a Patient, please check the following box:

**By checking this box, I attest that the patient has given his/her consent to provide the information in this application. I attest that the patient has given consent to the release of medical and financial information related to the Co-Pay application process and agrees with the following conditions, including the Patient Agreement.**

**Patient Agreement, Authorizations, Disclosures & Attestations:**

I agree that the information provided in this application is truthful and accurate. I agree to notify Patient Advocate Foundation (PAF) if the financial situation, insurance status, or medical condition change from what has been documented in this application.

I authorize my health care provider(s)/pharmacy(s) and my insurance company(ies) to disclose to the Patient Advocate Foundation and its employees, third-party administrators, agents and other representatives (collectively "the Foundation"), information about me, my current medical condition and my health insurance coverage. The Foundation agrees to treat any and all such information as confidential.

I agree that PAF and its donors will not be liable for any damages of any kind, without limitation to the success or failure of medication(s), or for any harm that it may cause. If accepted into the program, I understand that PAF offers financial support to insured patients who financially and medically qualify to access pharmaceutical co-payment assistance. While PAF will make every effort to grant assistance when needed, the program is limited by available resources and may be discontinued or changed at any time. PAF is not responsible for maintaining insurance coverage continuation, if an insurance premium payment request is not received 15 business days prior to the due date.

I hereby authorize payment directly to the hospital, physician, pharmacy or other supplier herein named for the funds available to me through the Patient Advocate Foundation Co-Pay Relief program. I understand I am financially responsible for charges not covered by this program. While I am enrolled in the Co-Pay Relief program, I have complete freedom to choose and or change doctors, providers, suppliers, insurance companies and/or treatment related medications without affecting my continued eligibility.

I understand that prescription insurance coverage is required for continued enrollment in the program. I authorize and understand that the Co-Pay Relief program will contact my treating physician/provider with the status of my application to verify diagnosis and treatment status and for the purposes of provider payment. I understand that if my physician does not confirm my diagnosis and treatment status my award will be rescinded.

I understand that reported financial information will be verified through a third-party income verification service to confirm that the stated income meets program eligibility requirements. If the patient's income information cannot be verified, or the information provided during screening is significantly different than the third-party service reports, Patient Advocate Foundation Co-Pay Relief Program will require income documentation for review. As a condition of my award, I agree to submit requested proof of income documents within the designated timeframe. I understand that if I fail to submit the required documents by the deadline or if my documented household income does not fall within program guidelines my award will be rescinded.

I hereby authorize the Patient Advocate Foundation to:

**Use the information that I provided on the Co-Pay Relief application form to determine my eligibility for and assist with my continued participation in Co-Pay Relief.**

Use my social security number to access my credit information and information derived from public and other sources to estimate my income in conjunction with the eligibility determination process.

Contact me to seek feedback on Co-Pay Relief services.

**If you could rate the impact of this grant, if approved, what would it be?**

(10 being High impact – 1 being Little to No impact)?  ▼

# APPLICATION STATUS

## PATIENT PORTAL

### Application:

### Application Status

- The appropriate status will appear based on the information provided during the application process
- If additional documentation is needed, you may upload the documents on the dashboard for further review
- Please see the **Patient Portal Enhancement Guide** for further instructions on uploading documents

✓ **CONGRATULATIONS!**  
Your Application has been approved!

You are immediately eligible to begin submitting expenditures at this time

You are immediately eligible to begin submitting expenditures for your medication co-payments at your physician office, pharmacy, hospital and/or those you have previously paid. All eligible expenditures are processed on a first-come-first-serve basis regardless of submission method.

For your convenience, Patient Advocate Foundation Co-Pay Relief program has multiple methods of claim submission, including virtual pharmacy card, electronic upload on our portal, via fax using your unique barcoded cover sheet or by mail.

The virtual pharmacy card may be used at pharmacies or specialty pharmacies by giving your card information.

Expenditures may be submitted through the online portal where you, your pharmacy, and provider upload expenditures directly.

Claims may be made through mailing or faxing expenditures with the patient's unique barcode cover sheet.

**PENDING !**

Your Application Status is Currently Pending.

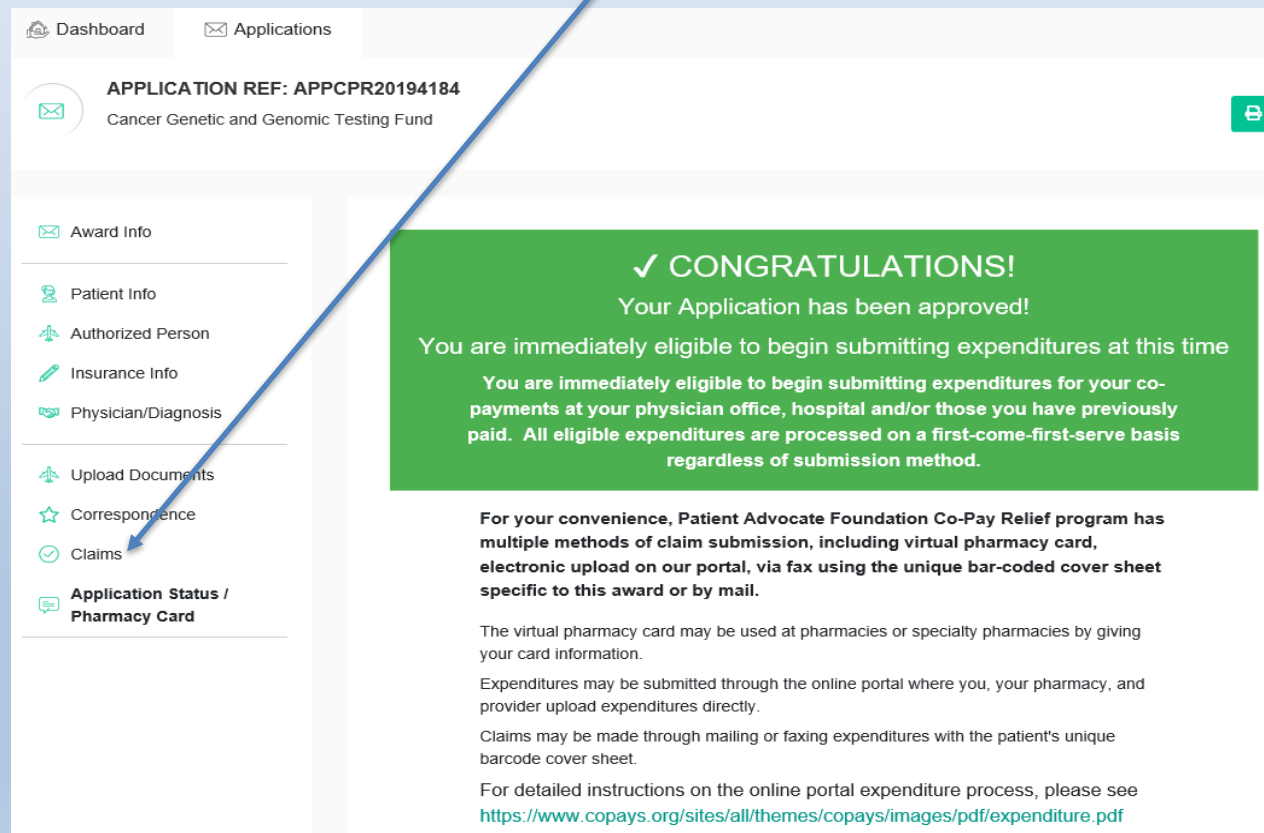
The Automated Income Verification system was unable to verify the information reported on your application. To review your application for eligibility, we will need to receive additional income documentation along with documentation verifying your Social Security Number. If we do not receive the required documentation within 30 days of your application, we will not be able to process the application through our system.

A letter has been attached to your application with details regarding what is required and can be viewed from the Applications>Correspondence tab.

# CLAIM SUBMISSION PATIENT PORTAL

## Submitting a Claim

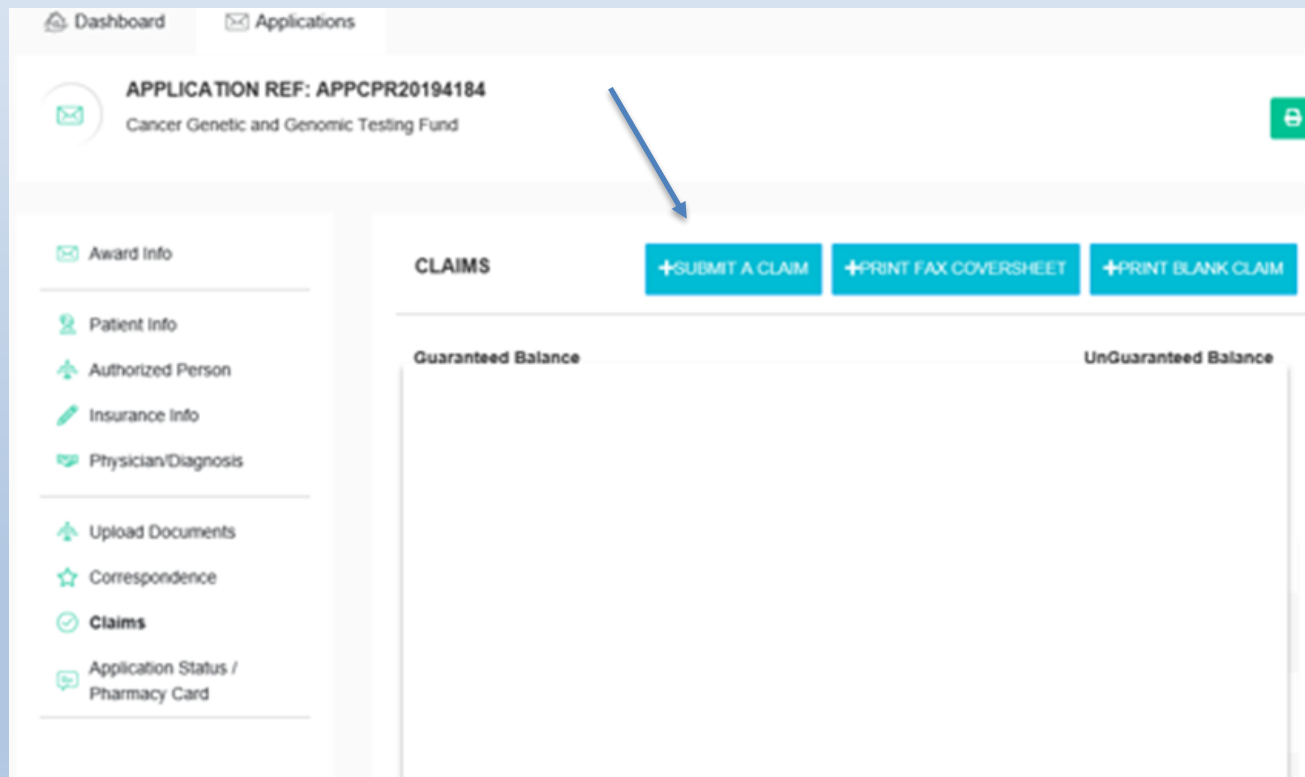
- To immediately submit a claim on an Approved application, select **Claims** from the Application Summary screen
- For detailed instructions on the online portal expenditure process, please visit <https://www.copays.org/sites/all/themes/copays/images/pdf/expenditure.pdf>



The screenshot shows a web portal interface. At the top, there are tabs for 'Dashboard' and 'Applications'. Below the tabs, the application reference number 'APPLICATION REF: APPCPR20194184' and the fund name 'Cancer Genetic and Genomic Testing Fund' are displayed. A green banner with a checkmark icon contains the text: '✓ CONGRATULATIONS! Your Application has been approved! You are immediately eligible to begin submitting expenditures at this time'. Below the banner, a detailed message states: 'You are immediately eligible to begin submitting expenditures for your co-payments at your physician office, hospital and/or those you have previously paid. All eligible expenditures are processed on a first-come-first-serve basis regardless of submission method.' A sidebar on the left lists various menu items: Award Info, Patient Info, Authorized Person, Insurance Info, Physician/Diagnosis, Upload Documents, Correspondence, Claims (highlighted with a blue arrow), and Application Status / Pharmacy Card. At the bottom of the main content area, there is a section titled 'For your convenience, Patient Advocate Foundation Co-Pay Relief program has multiple methods of claim submission, including virtual pharmacy card, electronic upload on our portal, via fax using the unique bar-coded cover sheet specific to this award or by mail.' This section includes instructions on how to use a virtual pharmacy card, how to submit expenditures through the online portal, and how to make claims by mailing or faxing. It concludes with a reference to the expenditure process instructions at <https://www.copays.org/sites/all/themes/copays/images/pdf/expenditure.pdf>.

## Submitting a Claim *(continued)*

- To submit a claim online click + **Submit A Claim** to be automatically taken to the Claim Submission Screen
- From this screen, you can print a blank Proof of Expenditure Form and a uniquely barcoded fax cover sheet specific to the award



## Submitting a Claim(continued)

### Payable To

- Select the desired payee under the “Payable To” drop down menu for reimbursement
- If “Patient” is selected as the payee from the drop-menu for patient reimbursement ; the patient’s address will automatically populate
- Click **Next** to proceed

**CLAIM SUBMISSION**  
Application Testing | APPCPR20194184

PAYABLE TO      DOCUMENTS      SIGNATURE

Payable To  
Patient

Payable to

**Patient**  
Application Testing,  
333 Some Street, Apt 123A,  
Newport News,  
VA, 23666, US

NEXT

# CLAIMS SUBMISSION PATIENT PORTAL

## Submitting a Claim (*continued*)

### Payable To

- If your address needs to be updated, select “Other” and complete the required fields, then select **Verify Address**.
- If “Address Verified” appears, click **Next** to proceed

**CLAIM SUBMISSION**  
Richie Valid | APPCPR20202816

PAYABLE TO      DOCUMENTS      SIGNATURE

Payable To  
Other

Payable to

**Other**

Name  
Richie Test

Address Line 1  
421 Butler Farm Rd

Address Line 2

City  
Hampton

State  
Virginia

ZIP Code  
23666

Address Verified.

VERIFY ADDRESS

NEXT



# CLAIMS SUBMISSION PATIENT PORTAL

## Submitting a Claim *(continued)*

### Payable To

- If the system is unable to verify the address entered, please review and make necessary corrections. If the address provided is correct, click **Next** to proceed.

**CLAIM SUBMISSION**  
Richie Valid | APPCPR20202816

PAYABLE TO      DOCUMENTS      SIGNATURE

Payable To  
Other

Payable to

**Other**

Name Richie Test	Address Line 1 123 Wrong Road	Address Line 2
City Newport News	State Virginia <input type="button" value="v"/>	ZIP Code 23602

Please ensure that you have entered a valid address. We are unable to verify the address entered; however, if the address you provided is correct, please proceed.

## Submitting a Claim(*continued*)

## CLAIMS SUBMISSION PATIENT PORTAL

### Payable To

- If **Provider** is selected as the payee from the drop-menu for provider reimbursement, the payment will be issued to the provider listed on the supporting documents
- Click **Next** to proceed

### CLAIM SUBMISSION

Application Testing | APPCPR20194184

PAYABLE TO	DOCUMENTS	SIGNATURE
------------	-----------	-----------

Payable To  
Provider

Payable to

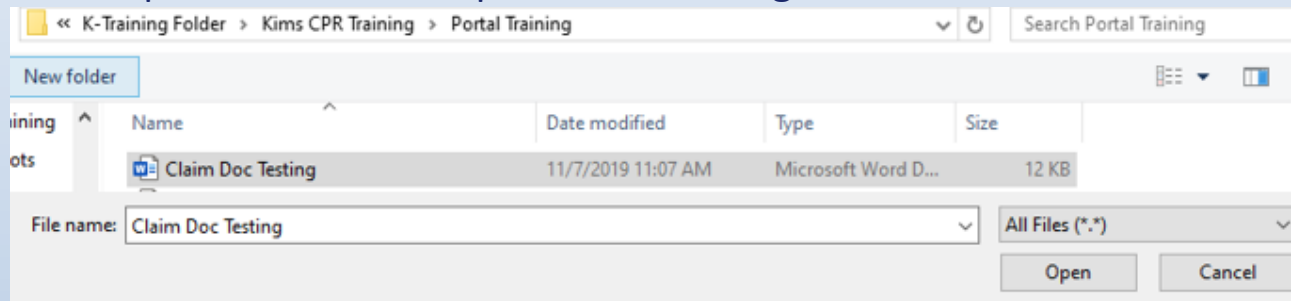
**Provider**  
Claim will be settled to the provider in the supporting document

NEXT

## Submitting a claim

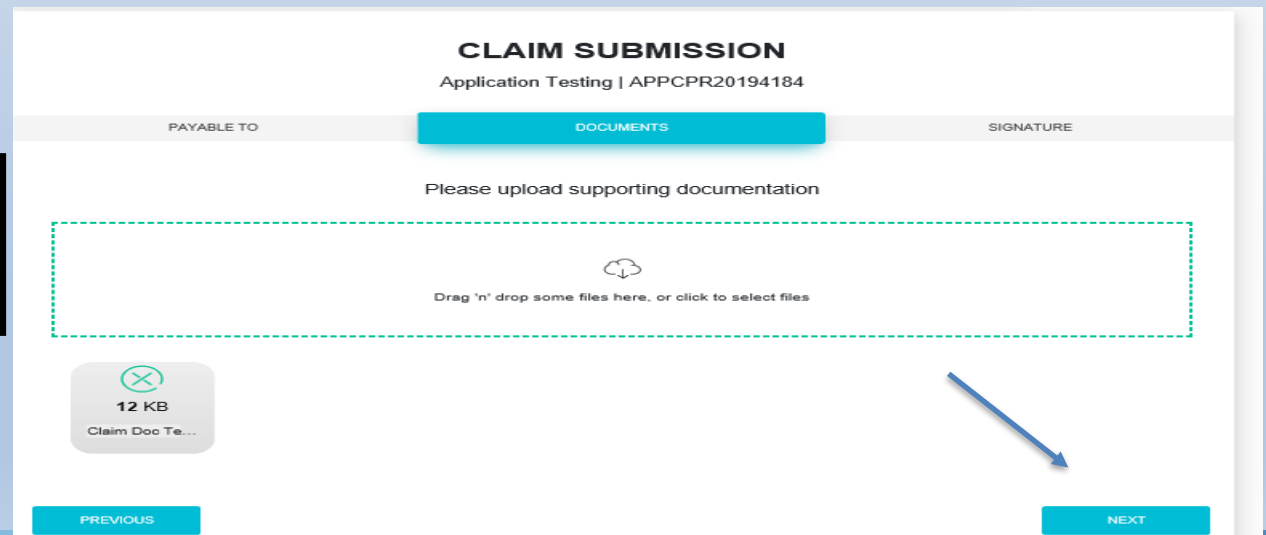
### Uploading supporting documents

- To submit supporting documentation, simply drag and drop the file or click the box to upload required documents
- Your document(s) will appear on this screen once they have been successfully uploaded
- Once complete, click **Next** to proceed to the **Signature** tab



### QUICK TIP

For patient reimbursement, proof of payment is required



**CLAIM SUBMISSION**  
Application Testing | APPCPR20194184

PAYABLE TO      DOCUMENTS      SIGNATURE

Please upload supporting documentation

Drag 'n' drop some files here, or click to select files

12 KB  
Claim Doc Te...

PREVIOUS      NEXT

# CLAIMS SUBMISSION PATIENT PORTAL

## Submitting a Claim

- Review the Claim Attestation
- Enter your electronic signature
- Click Sign and Submit
- You will be redirected to the Dashboard
- To learn about the new Dashboard and its features, view the **Patient Enhancement User Guide**

### CLAIM SUBMISSION

Application Testing | APPCPR20194184

PAYABLE TO	DOCUMENTS	SIGNATURE
------------	-----------	-----------

I attest that the information supplied is complete, accurate and supported in the patient's medical records. I understand this information is for the sole use of the Patient Advocate Foundation Co-Pay Relief Program, its representatives, and/or agents selected in order to assess the patient's eligibility for participation in the program. I understand that the assistance is temporary, and the patient may be asked to reapply at designated intervals.

**Electronic Signature:**

I hereby certify that the foregoing statements, including any accompanying statements and/or documents submitted are true, complete and accurate to the best of my knowledge. Please enter a value in the field below that represents you signing this document.

E-Signature (Your Name)  
Application Testing

[PREVIOUS](#) [SIGN AND SUBMIT](#)



Patient Advocate Foundation  
**CO-PAY RELIEF** <sup>SM</sup>

DISPENSING HELP, DELIVERING HOPE

**Contact Information**

421 Butler Farm Road  
Hampton, VA 23666

**Have Questions about using the Portals? Call us!**

Phone: (866) 512-3861, **Option 5**  
(Portal Inquiries/Technical Issues)

Fax: (757) 952-0119

Website: [www.copays.org](http://www.copays.org)

E-Mail: [cpr@patientadvocate.org](mailto:cpr@patientadvocate.org)



## PATIENT PORTAL DASHBOARD USER GUIDE



## Welcome to the Patient Dashboard!

Our goal with the patient dashboard is to deliver an improved online experience that is more efficient, provides more actionable information to you based on your needs and is in a format that is customizable and takes less of your valuable time to use!

# TABLE OF CONTENTS

## PATIENT PORTAL DASHBOARD

This guide will walk you through the enhanced features of your dashboard, to include:

- **Dashboard Features (pages 4-7)**
- **Applications Tab (pages 8-13)**
- **Contact Information (page 14)**



# LANDING PAGE PATIENT PORTAL DASHBOARD

The landing page consists of two parts:

- **Dashboard**

- Your Recently Created Application
- Recent Activities
- Actions Required by you

- **Applications**

- List of all the applications in your account
- Create New Applications

The screenshot displays the Patient Portal Dashboard with the following elements:

- Navigation:** Dashboard (active) and Applications.
- Patient Dashboard:** Includes a profile icon and the text "List of all the Action Items".
- Recently Created Application:**
  - Application Testing Breast Cancer** (Status: APPROVED)
  - Award Year: --
  - Balance: \$ 2250.00
  - Eff Date: Oct 30, 2019 | Expiry: Oct 30, 2020
  - View Application Details
- Recent Activities:**
  - Application Testing: App ref P-166991 is Claim Received (View Details)
  - Application Testing: App ref P-166894 is Claim Paid (View Details)
  - Application Testing: App ref P-166894 is Claim In Process (View Details)
  - View All >>
- Actions Required:** No Actions found! (Illustration of people interacting with a screen)

Dashboard:

Recently Created Application

The Recently Created Application section will display the following information:

- Patient’s Name
- Selected Diagnosis
- Application Status (Approved, Pending or Denied)
- Account Balance
- Approval (Eff)/Expiration(Expiry) Dates
- Action Buttons
- View Application Details
  - Allows the user to view specific details of the application

Recently Created Application

Application Testing  
Breast Cancer

APPROVED

Award Year : 2019

Balance:  
\$ 2200.00

Eff Date:            Expiry:  
Oct 30, 2019    Oct 30, 2020

[View Application Details](#)



**QUICK TIP**  
Select the Action Button to:

- View Claims
- View Documents
- View Virtual Pharmacy Card

### Dashboard:

#### Recent Activities

- The Recent Activities section will show the three most recent activities on the patient's account
- To view additional activities, click **View All**
- View Details
  - Allows the user to view specific details of the selected activity

#### Recent Activities

**Application Testing**  
App ref P-167135 is Claim Received  
[View Details](#)

**Application Testing**  
App ref APPCPR20194559 is Application Approved  
[View Details](#)

**Application Testing**  
App ref APPCPR20194559 is Application Review  
[View Details](#)

[View All >>](#)

### Dashboard:

### Actions Required

- The Actions Required section will provide the user with information on the most current time-sensitive actions that are necessary for:
  - Pending accounts that are missing information/documentation
  - Reminders about award utilization requirements for approved accounts
  - Reminders to reapply, if needed, at the end of the award period
- To view additional actions required, click **View All**

Ref	Patient	Actions
Income Document is Missing	Application Testing	Complete Action
Diagnosis Verification is missing	Application Testing	Complete Action

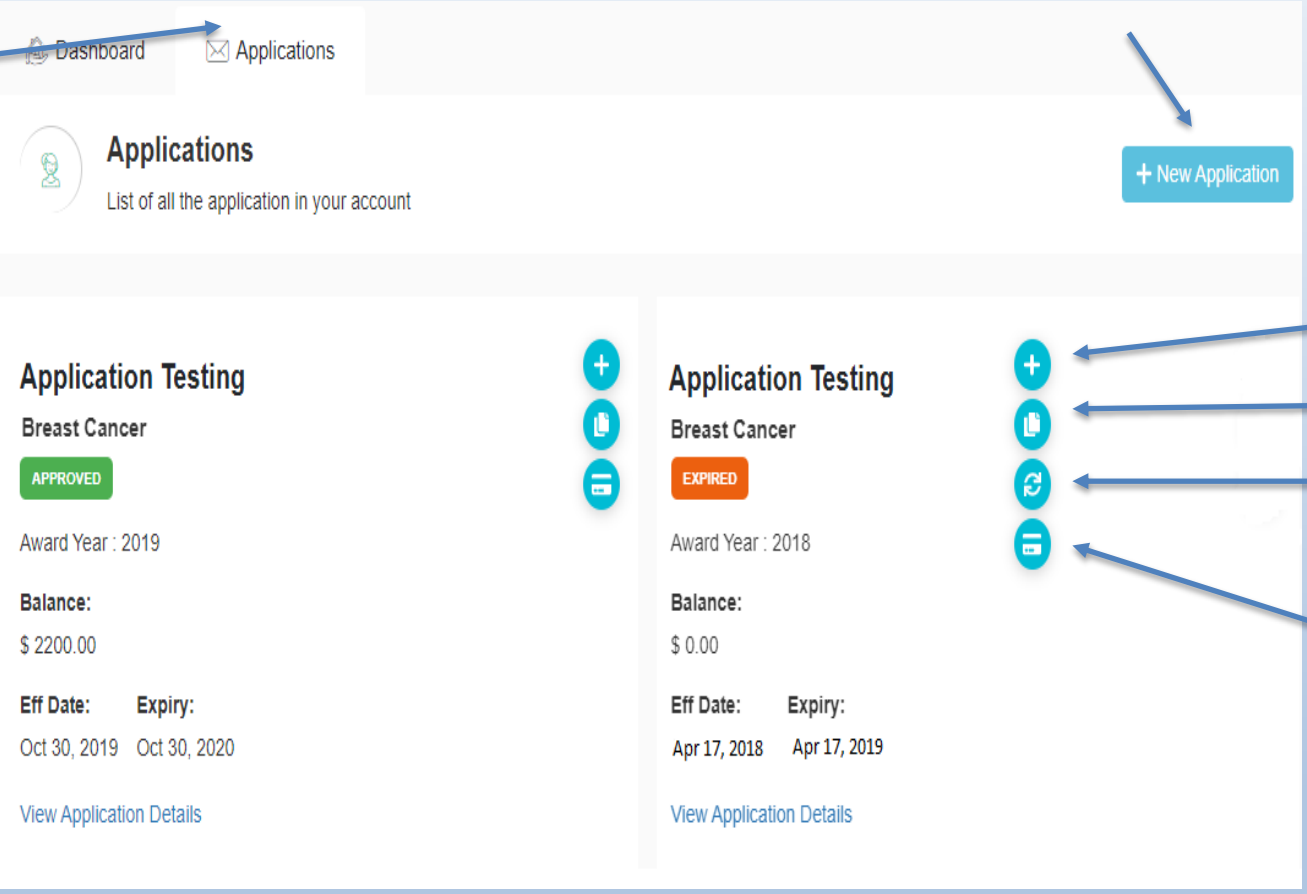
[View All >>](#)

**QUICK TIP**  
Select the **Complete Action** Button to upload the required document(s)

# DASHBOARD FEATURES PATIENT PORTAL

## Applications: Landing Page

- From the landing page, click the **Applications** tab to view details of all the applications in your account
- First-time applicants will need to click **+New Application** to create an application
- User will be able to complete actions within a specific application by selecting an action button
- View Application Details
  - Allows the user to view specific details of the selected application



**QUICK TIP**  
Select the Action Button to:

- View Claims
- View Documents
- Reapply (Existing Patients)
- View Virtual Pharmacy Card

### Applications:

### Award Info

- The **Award Info** section provides details about the award
  - Fund Name
  - Application Status
  - Effective/Expiry Dates
  - Balance
- The **Application Summary** section provides detailed information captured during the application process

The screenshot shows a patient portal interface. At the top, there are navigation tabs for 'Dashboard' and 'Applications'. Below this, the application details are displayed: 'APPLICATION REF: APPCPR20194184' and 'Breast Cancer'. A green 'Print' button is visible in the top right corner. On the left side, there is a sidebar menu with options: 'Award Info', 'Patient Info', 'Authorized Person', 'Insurance Info', 'Physician/Diagnosis', 'Upload Documents', 'Correspondence', 'Claims', and 'Application Status / Pharmacy Card'. The main content area is titled 'AWARD INFO' and includes a green 'APPROVED' status badge. The details are as follows:

<b>Fund Applied for :</b> Breast Cancer	<b>Effective Date :</b> October 30, 2019	<b>Balance :</b> \$ 16,000.00
<b>Award Year :</b> 2019	<b>Expiry Date :</b> October 30, 2020	

**QUICK TIP**  
Click the **Print** button to print a copy of the completed application

# DASHBOARD FEATURES

## PATIENT PORTAL

### Applications:

### Upload Documents

- The **Upload Documents** section will allow the user to upload required documents for pending and approved applications
- The user can also search and filter to review their uploaded documents by using several search methods

**UPLOADED DOCUMENTS**

D-Case Id	Uploaded Doc...	Status	Uploaded On	Action
APPCPR20194...	IRA Income	APPROVED	10/30/2019	Download
APPCPR20194...	Social Security ...	APPROVED	10/30/2019	Download
D-153662	SSNVerification...	RECEIVED	10/30/2019	Download

**QUICK TIPS**

1. To narrow your search results, enter specific document identifiers or click the column header to sort
2. You can also show additional rows to expand your search
3. Select the Action Button to:  
View your uploaded document(s)

# DASHBOARD FEATURES PATIENT PORTAL

## Applications:

### Correspondence

- The **Correspondence** section allows the user to view all correspondence received from PAF

The screenshot shows the 'Applications' tab in the Patient Advocate Foundation Patient Portal. The main header displays 'APPLICATION REF: APPCPR20194184' and 'Breast Cancer'. A left-hand navigation menu includes options like 'Award Info', 'Patient Info', 'Authorized Person', 'Insurance Info', 'Physician/Diagnosis', 'Upload Documents', 'Correspondence' (highlighted with a red box), 'Claims', and 'Application Status / Pharmacy Card'. The main content area is titled 'CORRESPONDENCE' and shows a list of documents received from PAF on Oct 30, 2019. Each document has a green download icon in the 'Action' column.

Correspondence	Received On	Action
Income Eligibility Letter.pdf	Oct 30, 2019	
Application Fax Cover Sheet.pdf	Oct 30, 2019	
Patient Enrollment Application.pdf	Oct 30, 2019	
Application Fax Cover Sheet.pdf	Oct 30, 2019	
Instant Approval - CPR Full Award Letter.pdf	Oct 30, 2019	
Guide to Expenditure Payments.pdf	Oct 30, 2019	
Proof Of Expenditure Form.pdf	Oct 30, 2019	
Expenditure Fax Cover Sheet.pdf	Oct 30, 2019	
EFT Instructions and EFT Form.pdf	Oct 30, 2019	

**QUICK TIP**  
Select the Action Button to:  
• Download Correspondence



# DASHBOARD FEATURES PATIENT PORTAL

## Applications:

### Claims

- The **Claim** section allows the user to view all claims associated with the application
- To enter a claim from this screen, select **+Submit A Claim**
- From this screen, you can also print a blank Proof of Expenditure Form and a uniquely barcoded fax cover sheet specific to the award

Dashboard Applications

APPLICATION REF: APPCPR20194184  
Breast Cancer

Award Info  
Patient Info  
Authorized Person  
Insurance Info  
Physician/Diagnosis  
Upload Documents  
Correspondence  
**Claims**  
Application Status / Pharmacy Card

CLAIMS +SUBMIT A CLAIM +PRINT FAX COVERSHEET +PRINT BLANK CLAIM

Guaranteed Balance UnGuaranteed Balance 0.0

Show 5 rows entries

POE ID	Check No	Submissio...	Amount Su...	Status	Action
P-167110		11/25/2019	0.00	PENDING	
P-167029		11/12/2019	0.00	PENDING	
P-166992	665982	11/08/2019	50.00	PAID	
P-166991		11/08/2019	0.00	PENDING	
P-166994	665950	10/30/2019	250.00	PAID	

Showing 1 to 5 of 5 entries Previous Page 1 of 1 Next

### QUICK TIPS

1. To narrow your search results, enter specific claim details or click the column header to sort
2. You can also show additional rows to expand your search
3. Select the Action Button to:
  - View uploaded document(s)

### Applications:

### Application Status/Pharmacy Card

- The **Application Status/Pharmacy Card** section provides you with the current account status
- Approved patients can also view and print their Virtual Pharmacy Card

The screenshot shows a patient portal interface. At the top, there are navigation tabs for 'Dashboard' and 'Applications'. Below this, the application reference number 'APPCPR20194387' and the diagnosis 'Breast Cancer' are displayed. A green banner with a checkmark icon reads 'CONGRATULATIONS! Your Application has been approved!'. Below the banner, a message states: 'You are immediately eligible to begin submitting expenditures at this time. You are immediately eligible to begin submitting expenditures for your co-payments at your physician office, hospital and/or those you have previously paid. All eligible expenditures are processed on a first-come-first-serve basis regardless of submission method.' A sidebar on the left contains a menu with items: 'Award Info', 'Patient Info', 'Authorized Person', 'Insurance Info', 'Physician/Diagnosis', 'Upload Documents', 'Correspondence', 'Claims', and 'Application Status / Pharmacy Card' (which is highlighted with a blue box). Below the message, there is a section titled 'For your convenience, Patient Advocate Foundation Co-Pay Relief program has multiple methods of claim submission...' followed by instructions on how to use the virtual pharmacy card. A box contains the following information: Patient: Application Testing, Fund: Breast Cancer, Award Period: 11/12/2019 - 11/12/2020, Cardholder: 1000203326, BIN: 610020, PCN: PXXPDMI, Group: 99993878. Contact information for pharmacy and patient inquiries is provided. At the bottom, there is a link to a PDF for detailed instructions and a 'Print this out!' button.



Patient Advocate Foundation  
**CO-PAY RELIEF**<sup>SM</sup>

DISPENSING HELP, DELIVERING HOPE

**Contact Information**

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Hampton, VA 23666

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