Reimbursement Request Form
OCREVUS Co-pay Program

100 Passaic Avenue, Suite 245, Fairfield, NJ 07004

Phone: (844) 672-6729

Fax: (855) 672-6729

www.OCREVUSCopay.com

Patient Name: _____ Date of Birth: _____

Legally Authorized Person Name *(if applicable)*: _____

Provider Name: _____

OCREVUS Co-pay Program Member ID: _____ Drug Name: _____

(Located on your Welcome Letter or at www.OCREVUSCopay.com)

Reimbursement Payable to: □ Patient □ Legally Authorized Person □ Provider (drug only)*

Name: _____

Address: _____

City/State/ZIP: _____

Amount Requested: _____

**If a provider completes the form, the Patient Attestation does not need to be signed.*

Patient Attestation and Signature

I attest that I have commercial insurance, an on-label prescription for OCREVUS and will not seek reimbursement from my health insurance or other patient assistance programs. I also certify that, to the best of my knowledge, the information on this reimbursement request form is true and correct.

Patient or Legally
Authorized Person Signature: _____

Date: _____

Please fax the completed form along with the patient's detailed Explanation of Benefits (EOB) to the fax number above or mail to the address above.

A detailed EOB includes insurance carrier name and logo, name of the plan, patient's responsibility, date of service and drug code broken out by name, J-code or National Drug Code (NDC). For reimbursement to patient, a copy of the paid receipt must also accompany the above.

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