

Reimbursement Request Form OCREVUS Co-pay Program

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Phone: (844) 672-6729

Fax: (855) 672-6729

www.OCREVUSCopay.com

Patient Name: _____ Date of Birth: _____
Legally Authorized Person Name <i>(if applicable)</i> : _____
Provider Name: _____
OCREVUS Co-pay Program Member ID: _____ Drug Name: _____
(Located on your Welcome Letter or at www.OCREVUSCopay.com)
Reimbursement Payable to: <input type="checkbox"/> Patient <input type="checkbox"/> Legally Authorized Person <input type="checkbox"/> Provider (drug only)*
Name: _____
Address: _____
City/State/ZIP: _____
Amount Requested: _____
<i>*If a provider completes the form, the Patient Attestation does not need to be signed.</i>
Patient Attestation and Signature
<i>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.</i>
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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