Reimbursement Request Form
HEMLIBRA Co-Pay Program

P.O. Box 15138 Newport Beach, CA 92659
Phone: (844) 436-2672
Fax: (855) 436-2672
www.HEMLIBRAcopay.com

Patient Name: _____ Date of Birth: _____

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

Provider Name: _____

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

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

Reimbursement Payable to: □ Patient □ Legally Authorized Person* □ Physician

Name: _____

Address: _____

City/State/ZIP: _____

Date of Service: _____ Amount Requested: _____

**Legally Authorized Person must be 18 Years of age or older and have legal authority to act on the patient's behalf*

Attestation and Signature

I attest that the patient has commercial insurance, an on-label prescription for HEMLIBRA and will not seek reimbursement from the health insurance plan 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 or Physician Signature: _____

Please Print Name: _____

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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