

# Reimbursement Request Form HEMLIBRA Co-Pay Program

P.O. Box 5087 Irvine, CA 92616

Phone: (844) 436-2672

Fax: (855) 436-2672

[www.HEMLIBRAcopay.com](http://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](http://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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