

**Reimbursement Request Form  
HEMLIBRA Co-pay Program**

100 Passaic Avenue, Suite 245, Fairfield, NJ 07004

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)	
<b>Reimbursement Payable to:</b> <input type="checkbox"/> Patient <input type="checkbox"/> Legally Authorized Person <input type="checkbox"/> Provider*	
Name: _____	
Address: _____	
City/State/ZIP: _____	
Amount Requested: _____	
<i>*If a provider completes the form, the Patient Attestation does not need to be signed.</i>	
<b>Patient Attestation and Signature</b>	
<i>I attest that I have commercial insurance, an on-label prescription for HEMLIBRA 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 or National Drug Code (NDC). For reimbursement to patient, a copy of the paid receipt must also accompany the above.**

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