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)

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

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 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.

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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