

Reimbursement Request Form

HEMLIBRA Co-pay Program

P.O. Box 15938, Newport Beach, CA 92659

Phone: (844) 436-2672

Fax: (855) 436-2672

www.hemlibracopay.com

Patient Name: _____	Date of Birth: _____
Legally Authorized Person Name <i>(if applicable)</i> : _____	
Provider Name: _____	
HEMLIBRA Co-pay Program Member ID: _____	Drug Name: _____
<small>(Located on your Welcome Letter or at www.hemlibracopay.com)</small>	
Reimbursement Payable to: <input type="checkbox"/> Patient <input type="checkbox"/> Legally Authorized Person* <input type="checkbox"/> Provider†	
Name: _____	
Address: _____	
City/State/ZIP: _____	
Date of Service: _____	Amount Requested: _____
<small>*Legally Authorized Person must be 18 Years of age or older and have legal authority to act on the patient's behalf †If a provider completes the form, the Patient Attestation does not need to be signed.</small>	
Patient Attestation and Signature	
<small>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.</small>	
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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