# Reimbursement Request Form
# ENSPRYNG Co-pay Program

**P.O Box 2106, Morristown, NJ 07962**

**Phone: (800) 636-0373**
**Fax: (866) 800-8432**
**www.ENSPRYNGcopay.com**

Patient Name:_____ Date of Birth: _____

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

Provider Name: _____

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

(Located on your Welcome Letter or at www.ENSPRYNGcopay.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 ENSPRYNG 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, 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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