

# 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 <i>(if applicable)</i> : _____	
Provider Name: _____	
ENSPRYNG Co-pay Program Member ID: _____	Drug Name: _____
<i>(Located on your Welcome Letter or at www.ENSPRYNGcopay.com)</i>	
<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 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.</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, 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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