Reimbursement Request Form

Genentech BioOncology® Co-pay Assistance Program

BIONCOLOGY®
CO-PAY ASSISTANCE PROGRAM

Patient Name: _____ Date of Birth: _____

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

Provider Name: _____

Genentech BioOncology® Co-pay Assistance Program Member ID: _____

Drug Name: _____

(Located on your Welcome Letter or at www.CopayAssistanceNow.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 an FDA-approved Genentech BioOncology® product 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 (877) 885-2607 or mail it to 100 Passaic Avenue, Suite 245, Fairfield, NJ 07004.

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.

Genentech
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100 Passaic Avenue, Suite 245, Fairfield, NJ 07004
Phone: (855) 692-6729 Fax: (877) 885-2607
www.CopayAssistanceNow.com