Reimbursement Request Form
ESBRIET Co-Pay Program

P.O. Box 2106 Morristown, NJ 07962

Phone: (877) 780-4958

Fax: (888) 280-8689

www.ESBRIETcopay.com

Patient Name:_____ Date of Birth: _____

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

Provider Name: _____

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

(Located on your Welcome Letter or at www.ESBRIETcopay.com)

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

Name:_____

Address:_____

City/State/ZIP:_____

Date of Service: _____ Amount Requested: _____

**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.

Patient Attestation and Signature

I attest that I have commercial insurance, an on-label prescription for ESBRIET 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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