Copay Reimbursement Form

Phone: 877-QALSODY (877-725-7639)

SUBMIT VIA FAX to [1-908-809-6244]

**SUBMIT VIA DIRECT MAIL to [Biogen Claims
PO Box 2355
Morristown, NJ 07962]**

Submit itemized EOB or Remittance Advice along with summary of billed charges AND copy of reimbursement claim form

Date of Service (DOS): _____

PATIENT INFORMATION

_____ _____
First Name *Last Name*

☐ *Male* ☐ *Female* _____
Date of Birth

[EC15608001] _____
PATIENT ASSIGNED Program GROUP # *PATIENT ASSIGNED Program ID #*

CONTACT INFORMATION

(*For individual submitting this form*)

_____ _____
First Name *Last Name*

_____
Email Address

_____ _____
Primary Phone *Fax #*

Best time to contact ☐ *Morning* ☐ *Afternoon* ☐ *Evening*

PAYEE INFORMATION

For reimbursement of the drug and/or procedure indicated here, the check should be sent to:

_____
List name checks payable to. Note: Payments are made to physicians or site of care facilities only on behalf of the patient.

_____
Clinic/Hospital affiliation of where check should be sent to

_____
Address

_____
City

_____ _____ _____
State *ZIP Code* *Telephone*

_____ _____
NPI # (Required information) *State License #*

_____ _____
Tax ID # (Required information) *Fax #*

THE [QALSODY™ (tofersen)] COPAY ASSISTANCE PROGRAM IS TO BE USED ONLY IN CONJUNCTION WITH A COMMERCIAL PAYER

This claim reimbursement form is for:
(*Please check the appropriate boxes*)

☐ **Drug Copay Program**

- ☐ Unclassified Drug Codes – J3490, J3590, or C9399
  Requested reimbursement amount: $ _____
- ☐ NDC 64406-0109-01
  Requested reimbursement amount: $ _____

☐ **Imaging Procedure/Guidance**

- ☐ Fluoroscopy – 77003
  Requested reimbursement amount: $ _____
- ☐ Ultrasound – 76942
  Requested reimbursement amount: $ _____
- ☐ CT Guidance – 77012
  Requested reimbursement amount: $ _____

☐ **Surgical Procedure and Drug Admin**

- ☐ Intrathecal drug admin – 96450
  Requested reimbursement amount: $ _____
- ☐ Lumbar puncture, therapeutic – 62272
  Requested reimbursement amount: $ _____

☐ **Recovery Room**

- ☐ Recovery Room – General Classification – REV 710
  Requested reimbursement amount: $ _____

Biogen