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