Copay Reimbursement Form

Phone: 1-844-477-4672

SUBMIT VIA FAX to 1-888-656-4343

SUBMIT VIA EMAIL (.pdf only) to CopayProgram@Biogen.com

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

EC15601001 _____
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

_____
Address

_____
City

_____ _____ _____
State *ZIP Code* *Telephone*

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

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

THE SPINRAZA COPAY AND PROCEDURE 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
- ☐ Classified Drug Codes – J2326 or C9489
  Requested reimbursement amount: $ _____
- ☐ Unclassified Drug Codes – J3490, J3590, or C9399
  Requested reimbursement amount: $ _____
- ☐ NDC 64406-058-01 & 64406-0058-01
  Requested reimbursement amount: $ _____

☐ Procedure Copay Program
- ☐ Anesthesia
  - ☐ Inhalation – 00635
    Requested reimbursement amount: $ _____
  - ☐ IV Sedation – 99100
    Requested reimbursement amount: $ _____
  - ☐ REV – 370
    Requested reimbursement amount: $ _____
  - ☐ Moderate Sedation – 99151, 99152, 99153, 99155, 99156 and 99157
    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, diagnostic – 62270
    Requested reimbursement amount: $ _____
  - ☐ Spinal puncture, Lumbar, diagnostic; with fluoroscopic or CT guidance – 62328
    Requested reimbursement amount: $ _____
  - ☐ Lumbar puncture, therapeutic – 62272
    Requested reimbursement amount: $ _____
  - ☐ Spinal puncture, Lumbar, therapeutic, for drainage; with fluoroscopic or CT guidance – 62329
    Requested reimbursement amount: $ _____
  - ☐ Injection(s), without imaging guidance – 62320 or 62322
    Requested reimbursement amount: $ _____
  - ☐ Injection(s), with imaging guidance – 62321 or 62323
    Requested reimbursement amount: $ _____
- ☐ Recovery Room
  - ☐ Recovery Room – General Classification – REV 710
    Requested reimbursement amount: $ _____

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