

**Reimbursement Request Form
Pulmozyme Financial Support Center**

P.O. Box 2106, Morristown, NJ 07962

Phone: (877) 794-8723

Fax: (833) 307-2197

www.Pulmozymesupport.com

Patient Name: _____	Date of Birth: _____
Legally Authorized Person Name: _____	
Provider Name: _____	
PULMOZYNE Co-pay Program Member ID: _____	Drug Name: _____
(Located on your Welcome Letter or at www.Pulmozymesupport.com)	
Reimbursement Payable to: <input type="checkbox"/> Patient <input type="checkbox"/> Legally Authorized Person <input type="checkbox"/> Provider*	
Name: _____	
Address: _____	
City/State/ZIP: _____	
Amount Requested: _____	
<i>*If a provider completes the form, the Patient Attestation does not need to be signed.</i>	
Patient Attestation and Signature	
<i>I attest that I have commercial insurance, an on-label prescription for PULMOZYME 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.</i>	
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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