

# Benefit Verification Request Form

Reimbursement Resource Center  
P.O. Box 221425  
Charlotte, NC 28222-1245  
Phone: 800-745-2967  
Fax: 866-216-5292

Patients or healthcare professionals requesting patient-specific verification of benefits for an injectable anticoagulant should fax this signed and completed request form to the GlaxoSmithKline Reimbursement Resource Center at 866-216-5292. If possible, please attach a copy of the patient's health insurance and prescription drug card(s) (front and back). Patient benefits will be researched and communicated back to you within two business days, or as soon as possible following receipt of information from the payer. If you have any questions, please call the GlaxoSmithKline Reimbursement Resource Center at 800-745-2967.

**IMPORTANT: Patients must sign and return the attached Patient Authorization to Release and Disclose Medical Information before we can initiate patient-specific research.**

## **PATIENT INFORMATION** or fax in a copy of front and back of patient's insurance card(s)

Patient Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: M F

### **Insurance Information**

Primary Insurer: \_\_\_\_\_  
Policy ID Number: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_

Secondary Insurer: \_\_\_\_\_  
Policy ID Number: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_

Primary Rx Insurer: \_\_\_\_\_  
Is this a Medicare Part D plan?  Yes  No  
Policy ID Number: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Secondary Rx Insurer: \_\_\_\_\_  
Is this a Medicare Part D plan?  Yes  No  
Policy ID Number: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Which site of service should be considered during the benefit verification?  Home  Hospital Outpatient  Physician Office  
 Other: \_\_\_\_\_

### **Treatment Information**

Primary Diagnosis: \_\_\_\_\_ ICD-9-CM: \_\_\_\_\_  
Anticipated Treatment Start Date: \_\_\_\_\_  
Rx Directions (including length of planned treatment): \_\_\_\_\_

## **PHYSICIAN / PRESCRIBER INFORMATION**

Physician/Prescriber Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_  
Office Contact: \_\_\_\_\_  
Tax ID Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Fax: (\_\_\_\_\_) \_\_\_\_\_  
Best Time to Call: \_\_\_\_\_  
National Provider Identifier Number: \_\_\_\_\_

### **Payer-Specific Provider Number (healthcare professionals only):**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_