

Copay Reimbursement Form

Phone: 844-4-SPINRAZA (844-477-4672)

SUBMIT VIA FAX to 1-888-656-4343

SUBMIT VIA EMAIL to copayprogram@biogen.com

SUBMIT ONLINE (.pdf only) by logging into

<https://copay.mybiogen.com/>.

SUBMIT VIA DIRECT MAIL TO IQVIA, 430 Mountain

Avenue, Suite 105 New Providence, NJ 07974, Attn: Claims Processing Department



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

Date of Service (DOS): _____

PATIENT INFORMATION

Patient First Name Patient Last Name

Male Female _____
Date of Birth

CONTACT INFORMATION

(for individual submitting this form)

Contact First Name Contact Last Name

Email Address

Contact Primary Phone Contact Fax #

Best time to contact Morning Afternoon Evening

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

Drug Copay Program

Classified Drug Code - J2326
Requested Reimbursement Amount \$ _____

NDC 66406-058-01 or NDC 66406-0058-01
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, therapeutic - 62272
Requested Reimbursement Amount \$ _____

Spinal puncture, Lumbar, therapeutic for drainage; with fluoroscopic or CT guidance - 62329
Requested Reimbursement Amount \$ _____

Recovery Room

Recovery Room - General Classification - REV710
Requested Reimbursement Amount \$ _____

Observation or Inpatient Care

Observation - 99234, 99235 or 99236
Requested Reimbursement Amount \$ _____

PAYEE INFORMATION

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

Clinic/Hospital affiliation where payment should be sent to. NOTE: Payments are made to physicians or site of care facilities only on behalf of the patient.

Address

City

State ZIP Code Phone

NPI (Required Information) State License Number

Tax ID (Required Information) Fax #



THE SPINRAZA COPAY AND PROCEDURE ASSISTANCE PROGRAM IS TO BE USED ONLY IN CONJUNCTION WITH A COMMERCIAL PAYER