

Copay Reimbursement Form

Phone: 1-844-477-4672

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



SUBMIT VIA FAX to 1-888-656-4343

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

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 # _____

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: \$ _____



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

