# PATIENT COPAY REIMBURSEMENT FORM

**In order to receive reimbursement, you must submit this form within 180 days from date of service**

For questions, call 1-855-EPIOXA, Option 2  Monday - Friday, 8:00 AM - 8:00 PM EST

**Please complete all sections of this form. All information is required unless marked as optional. Please submit one form per explanation of benefits (EOB). (If eligible, estimated time for reimbursement is 2-3 weeks).**

## SECTION 1: PATIENT INFORMATION

First Name:  Last Name:

Date of Birth (MM/DD/YYY):  Gender:  F  M  U

Address (Street, Apt/Suite):

City:  State/ZIP:

Phone:  Email:

## SECTION 2: TREATMENT DETAILS

Date of Service:  Product Name:

Eye Treated?  Right  Left  Bilateral

Out-of-Pocket ($) Classified Drug <>

Out-of-Pocket ($) Classified Procedure <>

## SECTION 3: PRESCRIBER INFORMATION

First Name:  Last Name:

Address (Street, Apt/Suite):

City:  State/ZIP:

Phone:  Email:

NPI Number (Optional):

## SECTION 4: COPAY PAYMENT STATUS

Have you paid the copay out-of-pocket?  Yes  No

If Yes, and you are seeking reimbursement directly, proof of payment is required along with the Explanation of Benefits (EOB).
If No, the reimbursement will be issued directly to the provider.

EpioxaCareConnect™

Epioxa™
(riboflavin 5'-phosphate ophthalmic solution)

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## Patient Certification

I certify that my prescription medication for which I am seeking co-pay assistance is not paid for, in whole or in part, by any state or federal government program. The information I am providing is accurate to the best of my knowledge, and the medication co-pay expenses for which I am seeking assistance were actually incurred. I agree to the Terms and Conditions of the program.

Patient Signature: _____

(Patient must provide a wet handwritten signature)

Date: _____

## Submission Instructions

**Please submit this completed form along with:**

- A copy of your proof of payment (e.g., receipt, credit card statement, or canceled check). (Required if seeking patient reimbursement directly)
- A copy of your Explanation of Benefits (EOB) from your insurance provider.

**Submit via:**

Mail: <Program_Mailing Address>

Fax: <Progream_Fax Number>

Patient Portal: <Portal-submission Info>

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