# GSK Copay Program

IQVIA, Inc. / 430 Mountain Ave., Suite 105 / New Providence, NJ 07974 / Attn: Claims Processing Dept. www.iqvia.com Tel: 1-800-741-0375
Fax: 1-877-471-0343

Please complete this form and submit with all required information and attachments to be considered for reimbursement. *Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state or federally funded programs, nor for any amount covered by insurance, FSA or HSA - none of which are eligible for payment.*

## Patient Information

**Name** (Last, First): _____, _____

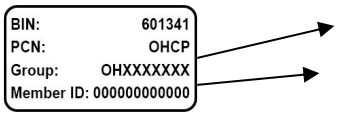
**Address** (Street): _____ **Date of Birth:** ☐☐-☐☐-☐☐

**Apt./Suite No.** _____ **City:** _____ **State:** ☐☐ **Zip:** ☐☐☐☐☐-☐☐☐☐

**Email:** _____@ _____ **Phone:** (  ) _____-_____ **Fax:** (  ) _____ - _____

(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

Please refer to the Pharmacy Claim box, found on your card or printed offer, for the required information. It will look similar to the example shown (right).




**Group:** OH☐☐☐☐☐☐☐

**Member ID:** ☐☐☐☐☐☐☐☐☐☐☐☐☐

[ ] Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.

## Insurance Information

Do you have Health Insurance: [ ] No [ ] Yes and my insurer for prescription benefits is: _____.
My insurance covered: [ ]This entire prescription [ ]None of this prescription [ ]All except copay of: $ _____.
This prescription was filled at [ ] a retail pharmacy store [ ] through mail order or specialty pharmacy (EOB required)*
***Specialty/Mail order claims require a copy of the Explanation of Benefits for this prescription from your insurance provider.**

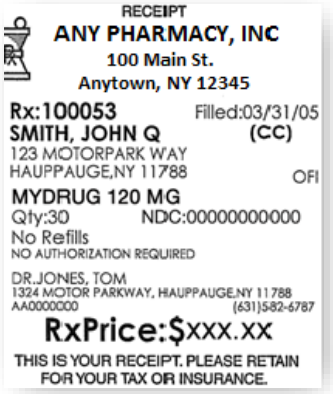
## Pharmacy Receipt

Mail this completed form along with the following items to the following address:

**Attn: Claims Processing Department,IQVIA, Inc.**
**430 Mountain Ave., Suite 105, New Providence, NJ 07974**

**Failure to include any of the following will result in claim rejection:**

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information ():
   - ✓ Patient name and address ✓ Pharmacy name, address and phone number
   - ✓ Doctor or health care provider name, address and phone number
   - ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
   - ✓ Overall prescription price and Copay amount/out of pocket expense paid
2. Copy of your EOB (if required in Insurance Information section above)
3. The cash register receipt with the amount paid for this prescription clearly identified
4. Copy of your primary insurance card (including both front and back of the card)


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788
OFI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-6787
RxPrice:$XXX.XX
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

## Certification Statement

"I, _____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law."

Claimant/Patient/Legal Guardian Signature: _____ Date_____

**Please allow 2 – 4 weeks for processing. This form can be used for multiple submissions.**
**For assistance completing this form, contact IQVIA, Inc. at 1-800-364-4767 and select the Patients option.**