Pfizer Vaccines Reimbursement Support Services
Insurance Verification Form

Phone: 1-866-744-3198 Fax: 1-866-744-3303

(Monday through Friday 8 AM – 8 PM ET)

Patient Information			
First and Last Name:			
Phone:		Date of Birth: ____/____/_____	☐ Male ☐ Female
Street Address:	City:	State:	Zip:

Primary Medical Insurance Information (attach copy, front and back, of patient insurance cards)		
Primary Insurance Name:		Phone #:
Subscriber Name:		Relationship to Patient:
Subscriber ID #:		Group ID #:
Subscriber Date of Birth: ____/____/____	Subscriber SSN #:	Employer Name:

Secondary Medical Insurance Information (attach copy, front and back, of patient insurance cards)		
Secondary Insurance Name:		Phone #:
Subscriber Name:		Relationship to Patient:
Subscriber ID #:		Group ID #:
Subscriber Date of Birth: ____/____/____	Subscriber SSN #:	Employer Name:

Vaccine Selection for Adolescents and Young Adults: ☐ TRUMENBA® (Meningococcal Group B Vaccine)

ICD-10 Code (select diagnosis code based on patient's medical record)

☐ Z23 Encounter for immunization

Prescriber Information			
First and Last Name:		Office Contact:	
Group Practice Name:			
Address:	City:	State:	Zip:
Phone #:		Fax #:	
NPI #:	Tax ID #:	PTAN # (Medicare pts only):	

Site of Care: ☐ Office ☐ Clinic ☐ Hospital ☐ Pharmacy ☐ Other

If Site of Care Information is different from address listed above, please complete the section below.

Facility Name:		Office Contact:	
Address:	City:	State:	Zip:
Phone #:		Fax #:	
NPI #:	Tax ID #:	PTAN # (Medicare pts only):	

By signing below, I certify that the information provided above is complete and accurate to the best of my knowledge. I also certify that I have obtained the written authorization of the patient to disclose the information here, including protected health information, and such other health or personal information to Pfizer Vaccines Reimbursement Support Services, Pfizer, and/or its agents as may be necessary to provide reimbursement support, including verifying my patient's insurance coverage and providing assistance with prior authorization and/or appeals on behalf of my patient, and that the disclosure of such information complies with applicable laws including the Health Insurance Portability and Accountability Act (HIPAA) as amended, and its implementing regulations.

Prescriber Signature	**Date**

While every effort is made to provide helpful information, Pfizer makes no representations about the eligibility or guarantee of coverage or reimbursement for any particular claim. Pfizer cannot guarantee success in obtaining third-party insurance reimbursement. Third party coverage and payment for medical products and services is complex and affected by numerous factors. It is always a provider's responsibility to determine and submit the appropriate codes, charges and modifiers for services that are rendered. Providers should contact third-party payors for specific information on their coding, coverage and payment policies. All coding and claims used by a provider in seeking reimbursement must be accurate, complete, and adequately documented in the applicable patient record. All services must be medically appropriate. You are also responsible for ensuring the security of the transmission of information to Pfizer, as well as the security of the information that Pfizer has transmitted to you. Pfizer shall not be liable for any theft, loss or unauthorized access to or interception of such data.

Please see enclosed full Prescribing Information for Trumenba in the pocket of the folder in which this form is housed, or visit www.TrumenbaPI.com

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HIPAA Authorization Form for the Disclosure of Patient Information by Personal Physician

PFIZER VACCINES REIMBURSEMENT SUPPORT SERVICES

DO NOT SUBMIT THIS FORM WITH YOUR APPLICATION—IT IS FOR PATIENT AND PRESCRIBER RECORDS ONLY

To the Patient: The Pfizer Vaccines Reimbursement Support Services ("the Program"), which is powered by Pfizer RxPathways®, helps verify patients' insurance benefits and explain coverage requirements for Pfizer vaccines. In order to provide the reimbursement support services through the Program, Pfizer, along with its affiliated companies and contractors who administer the Program, need to obtain certain information about you from your physician (who is also called your "Doctor" in this form). **Please complete this Authorization, sign and date it, and return it to your doctor**

To the Physician: Please retain the original signed Authorization with the patient's records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer

I request and authorize my Doctor, _____, to give Pfizer Inc, including representatives and contractors who work on behalf of Pfizer in this Program, and including McKesson Specialty Arizona, Inc. (collectively, "Pfizer"), my protected health information, including, but not limited to, information about my medical condition and treatments, which is necessary to complete my benefits investigation. The type of information that can be given under this authorization may include:

- My name and birth date
- My address and telephone number
- My social security number
- Information about my health benefits or health insurance coverage
- Information on my medical condition, as necessary

I understand that I may refuse to sign this authorization and that it is strictly voluntary. Further, I understand that my Doctor may not condition the provision of my treatment on my signing this authorization.

I know that I can cancel (revoke) this authorization at any time by writing to my Doctor at _____. If I cancel this authorization, then my Doctor will stop providing Pfizer and its representatives, with information about me. However, I cannot cancel actions that have already been taken by relying on my authorization.

I understand that once my Doctor gives Pfizer information about me based on this authorization, federal privacy laws may not prevent Pfizer from further disclosing my information. I also understand that signing this authorization does not guarantee that I will be accepted into a Pfizer patient assistance program.

This authorization will expire one (1) year after the date it is signed, below, or one (1) year after the last date I receive medicines under the Program, whichever is later, or as required by state law.

Patient or Personal Representative of Patient {*if personal representative, indicate authority to sign on behalf of Patient (if applicable)*}

Signature _____

Date _____

Name (*please print*) _____

Please return the signed form to your Doctor. You are entitled to a copy for your records.

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