DAIICHI SANKYO/AMERICAN REGENT IV IRON REIMBURSEMENT HOTLINE
INSURANCE VERIFICATION FORM

Phone: (877) 4-IV-IRON Fax: (888) 354-4856

PLEASE COMPLETE ALL SECTIONS AND FAX TO: (888) 354-4856. The Daiichi Sankyo/American Regent IV Iron Reimbursement Hotline will contact the insurance company or companies listed below to determine coverage for Venofer® and/or Injectafer® as requested.

Name of Contact Completing Form: _____ **Phone Number:** _____

Patient Information

PATIENT'S CONSENT IS REQUIRED TO CONDUCT INSURANCE RESEARCH By providing consent, the patient authorizes us to contact the insurer to conduct research and relay the patient's name, date of birth, social security number, diagnosis, and insurance information.

Do you have the patient's consent on file? ☐ **Yes** ☐ **No**

PATIENT NAME: _____

Address: _____

Phone Number: _____ Date of Birth: _____

Social Security Number: _____

Diagnosis and Other Pertinent Medical Information

PRODUCT REQUESTED: ☐ **Venofer** ☐ **Injectafer** Anticipated Date of Service: _____

Diagnosis: Primary Diagnosis: _____ Secondary Diagnosis: _____

Setting of Care: ☐ Physician's Office ☐ Hospital Outpatient ☐ Other (please specify): _____

Insurance Information

PRIMARY INSURANCE: (Insurer Name and State): _____

Participating Provider: ☐ Yes ☐ No Payer Provider Number: _____

Phone Number: _____ Fax Number: _____ Policy Holder's Name: _____

Social Security Number: _____ Date of Birth: _____

Employer Name: _____ Policy Number: _____ Group/Plan Number: _____

SECONDARY INSURANCE: (Insurer Name and State): _____

Participating Provider: ☐ Yes ☐ No Payer Provider Number: _____

Phone Number: _____ Fax Number: _____ Policy Holder's Name: _____

Social Security Number: _____ Date of Birth: _____

Employer Name: _____ Policy Number: _____ Group/Plan Number: _____

☐ *If you have tertiary insurance, please fill out an additional Insurance Verification Request Form*

Physician Information

PRESCRIBING PHYSICIAN NAME: _____

NPI Number: _____ Tax ID Number: _____

Facility Name: _____

Address: _____

Provider Specialty: _____ DEA Number: _____

Phone Number: _____ Fax Number: _____

IF PA IS REQUIRED, WOULD YOU LIKE US TO INITIATE THE PA PROCESS? ☐ **Yes** ☐ **No**