Bayer $0 Co-pay Assistance Programs

Co-pay Expenditure Form Instructions

Please follow the instructions below for completing and submitting a Co-pay Expenditure Form for a Bayer $0 Co-pay Assistance Program. This form will be required for a patient to be reimbursed for their out-of-pocket expense if co-payment is paid by the patient.

1) For each co-pay/coinsurance reimbursement request, please provide the following information:
    a. Date of Service
    b. Amount of co-pay/coinsurance reimbursement being requested for your **Bayer product**
    c. Whome the check should be made payable
        - **Important Note**: The reimbursement check can **only be made payable to the patient or person who paid the co-pay amount**
    d. Address to which the check should be mailed
    e. Proof of payment from pharmacy where co-payment was collected

2) The Co-pay Expenditure Form MUST be **signed and dated**. Once completed, please mail or fax the form **AND all required documentation** to:

Bayer $0 Co-pay Assistance Programs
C/O ConnectiveRx Claims Processing Center
P.O. Box 2355
Morristown, NJ 07962

OR

FAX: (844) 622-5475

3) Proof of payment **MUST** be included with the Co-pay Expenditure Form. Documents such as pharmacy receipts, explanation of benefits and/or claims that include the Bayer drug name or National Drug Code (NDC) number, **MUST** be included in order to be reimbursed for their out-of-pocket expense. **Reimbursement cannot be issued without acceptable expense documentation.**

4) Payment will be sent within 7 to 14 business days **after approval** of your request.

5) Co-pay expenses incurred prior to your enrollment in the $0 Co-pay Assistance Program or incurred after your Program eligibility term has ended, may not be eligible for reimbursement.

If you have any questions regarding the Co-pay Expenditure Form or the co-pay reimbursement process, please contact Bayer's $0 Co-pay Assistance Program at 1-888-412-2247 from 8:00 a.m. – 8:00 p.m. ET Monday through Friday.

IMPORANT NOTICE: This program is not valid for prescriptions eligible to be reimbursed, in whole or in party, by Medicaid, Medicare (including Medicare Part D), or other federal or state program (including any state prescription drug assistance programs). This program cannot be combined with any other rebate/coupon, free trial, or similar offer. This program is not transferable, is good only in the United States, its territories, and possessions. This program is subject to certain eligibility requirements. Bayer reserves the right to make eligibility determinations, monitor participation, ensure equitable product availability and modify or discontinue any of Bayer's $0 Co-pay Assistance Program at any time. By using this program, you understand and agree to comply with the terms and conditions set forth above. This program is not insurance.

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Please make additional copies of this form for future use.

Section 1 – Bayer Co-pay Assistance Reimbursement Form

ALL fields are required. Complete this form in its entirety and include supporting documentation to avoid delays in reimbursement.

The following 6 fields can be found on the pharmacy receipt:

Product Name:	Received/Date of Service (MM/DD/YYYY):
NDC:	Rx#:
Quantity:	Day Supply:
Patient First Name:	Patient Last Name:
Patient Date of Birth:	
Co-pay Card Group Number:	Co-pay Card Member ID:
Primary Payer/Insurance Name:	
Primary Payer Group Number:	Primary Payer ID:
Amount of Reimbursement Requested (Documentation Required):	
Make Check Payable to: **(Check can only be made payable to the patient or person who paid copay amount)**	
Address:	
City: State:	Zip:

Section 2 – Declaration

I verify that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the Bayer's $0 Co-pay Assistance Programs. I understand that assistance will terminate if the Program reasonably suspects any fraudulent activity relating to the assistance provided by the Program. I understand that assistance may be limited to the terms and conditions established by the Program and that the Program reserves the right at any time or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue any or all of the programs and the related eligibility criteria, or (iii) terminate assistance.

I authorize Bayer, the $0 Co-pay Assistance Program, their employees and agents, third party administrators, and other representatives to obtain information from my healthcare providers and insurance coverage information from my employer, insurance company(ies), or specialty pharmacy(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Signature (required): **Date:**

Please mail or fax this completed form along with required documentation to:

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C/O ConnectiveRx Claims Processing Center
P.O. Box 2355, Morristown, NJ 07962

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FAX: (844) 622-5475

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