

Visit: [AllerganEyeCue.com](http://AllerganEyeCue.com)

## OZURDEX® SAVINGS PROGRAM PHYSICIAN REIMBURSEMENT REQUEST FORM



\*Required information.

Thank you for using the OZURDEX® Savings Program. In order to process reimbursement, please complete this form within 180 days from date of service and upload to [AllerganEyeCue.com](http://AllerganEyeCue.com) or fax it, along with the required supporting documentation listed at the bottom of this page, to 1-866-676-4069. If your patient qualifies, estimated time for reimbursement is 3 days (ACH) or 2 to 4 weeks (check).

PATIENT

Patient first name\*: \_\_\_\_\_ Patient last name\*: \_\_\_\_\_ Date of birth\*: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient member ID\*: \_\_\_\_\_

This is the number you receive after enrollment.

PHYSICIAN

Reimbursement checks will be mailed to the address on the Explanation of Benefits (EOB); not applicable to ACH payment.

Physician first name\*: \_\_\_\_\_ Physician last name\*: \_\_\_\_\_

Office contact email address\*: \_\_\_\_\_

**For fax users only:** Please indicate payment preference type for claims reimbursement†: Electronic payment via ACH  Check

†Note: Registered portal users with an indicated payment preference in their account profile will receive reimbursement based on the selected method.

SUPPORTING DOCUMENTS  
TO INCLUDE

- Completed OZURDEX® Savings Program Reimbursement Request Form
- HCFA 1500 form
- EOB document(s): Should be obtained from the patient's insurer

COPAY ATTESTATION

I, \_\_\_\_\_, \_\_\_\_\_  
Physician's or delegate's name

hereby attest that I am the prescribing physician or a delegate authorized to sign on behalf of the prescribing physician and

that the patient listed above, on \_\_\_\_\_, received an OZURDEX® injection as part of the OZURDEX®  
Date of service\*

Savings Program from Allergan®. I also attest that all appropriate steps were completed to determine the appropriate copay

for my patient and that the information submitted to *Allergan EyeCue*® is accurate and complete to the best of my knowledge,

and I understand that any falsification, omission, or concealment of data may be subject to certain fines and/or liabilities.

I understand that this information will be used for operational purposes as part of the OZURDEX® Savings Program from Allergan®.

PHYSICIAN OR DELEGATE SIGNATURE (REQUIRED)

Physician or delegate signature\* \_\_\_\_\_ Date\* \_\_\_\_\_

Complete and upload all materials to [AllerganEyeCue.com](http://AllerganEyeCue.com) or fax to 1-866-676-4069.  
Questions? Contact our Help Desk at 1-866-698-7339 or visit [AllerganEyeCue.com](http://AllerganEyeCue.com).