

Complete this form and submit with the required documents to be considered for reimbursement.

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 provide this information found on your Savings Card, it will look similar to the example shown (right).

BIN: 601341
PCN: OHCP
RxGrp: OHXXXXXX
RxID: XXXXXXXXXX

RxGrp:
RxID:

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

Medical Documents

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

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

Please be sure to include all of the following to avoid claim rejection or delay:

1. Explanation of Benefits (EOB) or Remittance Advice (inclusive of HCPCS procedures and services codes). Remember to include suite #105 on the mailing address.
2. Copy of your primary insurance card (including both front and back of the card).

Certification Statement

☐ I certify that I am seeking financial assistance/support for product received by myself or my child and will utilize these funds upon receipt to pay the resulting balance owed to my provider.

I, _____, certify that I am self-insured or have commercial insurance and the information provided in this claim is complete and 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), Health Reimbursement Arrangement (HRA) 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 that my insurance provider does not prohibit participation in this program. I understand and accept the terms and conditions for participation in this program and understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Eligibility and Privacy Notice

Please see eligibility criteria in the accompanying letter. For information on how we collect and process your personal data, including the categories we collect, purposes for their rebate, and disclosures to third parties, visit <https://abbvie.com/PrivacyPatient>. Through my submission of the enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" on AbbVie's website.

Please allow 1 – 2 weeks for processing. This form can be used for multiple submissions.
For assistance completing this form, contact IQVIA at 877-832-9755 and select the Patients option.