800.564.0216

ARC of Support™ Reimbursement Services
ABRAXANE® Benefit Verification Request Form

Fax: 866.242.4141 / Phone: 800.564.0216 (press 3)

Please provide the following information by fax or phone. A reimbursement counselor will research the patient's current benefits for ABRAXANE for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin-bound), complete a Coverage Profile Report, and contact the provider either by phone or fax regarding the patient's current benefits for ABRAXANE.

PROVIDER INFORMATION

Physician Name: ______________________ Tax ID #: ______________________ Payer Specific Provider #: ____________

Site Name: ____

Address: ____

City: ______________________ State: ______________________ Zip: ______________________

Telephone: (________) ______________________ Fax: (_______) ______________________

Office Contact: ______________________________________ Best Time to Call: ________________

PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________ DOB: _______ / _________ / _________

Address: ____

City: ______________________ State: ______________________ Zip: ______________________

Telephone: (________) ______________________ Fax: (______) ______________________ SSN: _________ - ________-__________

PATIENT MEDICAL HISTORY

Diagnosis/ICD-9-CM Code: ____________________ Is the Cancer Metastatic? ☐ Yes ☐ No ABRAXANE Dose/Frequency: ____________________

Treatment History: ____

INSURANCE INFORMATION *(or attach a two-sided copy of the patient's insurance cards)*

Primary Insurance: ______________________________________ Phone Number: (_____) ____________

Policy Number: ______________________ Group Number: ______________________

Policy Holder (if different than patient)

First Name: ________________ Last Name: ________________ DOB: ______ / ______ / ______ SSN: ________ - ________ - __________

Secondary Insurance: ______________________________________ Phone Number: (_____) ____________

Policy Number: ______________________ Group Number: ______________________

Policy Holder (if different than patient)

First Name: ________________ Last Name: ________________ DOB: ______ / ______ / ______ SSN: ________ - ________ - __________

PATIENT CONSENT

The ARC of Support Reimbursement Services must have your consent to contact your insurance company to conduct benefit research. If we have your consent, please sign below.

Patient's Signature: ______________________________________ **Date:** ______________________

OR, if this benefit verification information is requested from the physician:
The ARC of Support Reimbursement Services must have your patient's written consent to share this medical information. If you have the patient's written consent to release this information on file, please sign below.

Physician Representative Signature: ______________________________ **Date:** ______________________

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