MIRENA BENEFIT VERIFICATION REQUEST FORM

PROVIDER INFORMATION:					
Prescribing Physician:					
Tax ID# **730792126**			NPI#		
Site Name: **Tulsa OB-GYN Associates, Inc.**					
Address: **2000 S. Wheeling Ave., Suite 800**					
City: **Tulsa**	State: **OK**		Zip: **74104**		
Phone: **(918)746-2255**		Fax: **(918) 746-2252**			
PATIENT INFORMATION					
Name:		Date of Birth:		SS#:	
Address:					
City:	State:		Zip:		
Home Phone:		Cell Phone:			
PATIENT INSURANCE INFORMATION					
Insurance Company (1)		Insurance Company (2)			
Phone:		Phone:			
Policy #:	Group #	Policy #:		Group #	
Policy Holder Information (if not patient)		Policy Holder information (if not patient)			
Name:		Name:			
Employer:		Employer:			
Relation to Patient:		Relation to Patient:			

HEALTHCARE PROVIDER AUTHORIZATION

I certify that Mirena® therapy is medically necessary and that this information is accurate to the best of my knowledge. I authorize TheraCom, Inc. in its capacity on behalf of Bayer HealthCare Pharmaceuticals to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information in this form to the insurer of the above-named patient and to obtain any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes. As my business associate, TheraCom is required to comply with and by it signature hereto, agrees that it will comply with the applicable requirements of 45 CFR 160.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

Healthcare Provider Signature:

PATIENT CONSENT

I AUTHORIZE THE Mirena Reimbursement Support Program to obtain information from my Health Care Provider, Insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of understanding my coverage for Mirena.

Patient Signature: Date:

FOR OFFICE USE ONLY 877-946-1000

Benefits Received_____ _____ **Patient Notified**_____ _____ **Accept**□ **Declined** □

Patient Due: IUD $_____ **Insertion $**_____ **IUD Ordered:**_____ _____

APPOINTMENT DATE:_____ **TIME:**_____ **SCHEDULED BY:**_____