CHECK REQUEST FORM

Please complete all required information [*]

1 Patient Enrollment Confirmation

*Patient First Name *Patient Last Name

*Prolia Co-Pay Member ID (Found on member's card)

Patient Mailing Address Apartment / Unit / Suite

City State Zip

2 Physician and Practice Confirmation

*Physician First Name *Physician Last Name

*Practice Name and Location

Practice Mailing Address Apartment / Unit / Suite

City State Zip

3 Check Information

*Check Recipient (Please check one) ☐ Patient ☐ Practice

Note for Practice: By checking this box, the Practice certifies that they only billed the patient for the appropriate amount of out-of-pocket cost for Prolia® after application of the Prolia® Co-pay Card benefits. The check will be mailed to the address provided for the marked recipient. Please make sure to provide the corresponding address in this form.

*Date(s) of Service (mm/dd/yyyy)

*Amount Requested *Signature

*In addition to the documentation required by the program, when selecting "Patient" as a check recipient, make sure to include **proof of payment** as part of the document submission.*

Preferred Fax-Back Number for Notification (Optional)

Entering a fax number here indicates you would like to receive fax confirmation that the check has been sent to the address provided.

Please send the completed form along with Explanation of Benefits (and Proof of Payment, if required) to:

- **FAX: 1-800-675-2661**

or

- **MAIL TO: 100 Passaic Ave, Suite 245, Fairfield NJ 07004**

Attention: The Prolia® Co-Pay Program