# INSURANCE VERIFICATION REQUEST FORM

**1-866-OZURDEX (phone) • 1-866-676-4069 (fax)**

***please print or type**

**REQUIRED**: **Do you have your patient's written consent to release patient identifiable information for the purpose of conducting insurance research?**

☐ Yes ☐ No **(If no, obtain consent from patient before forwarding this request).**

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|---|---|
| **Patient Information** | Patient Name: ______ ☐ M ☐ F<br>Date of Birth: ______ Social Security Number: ______<br>Address: ______<br>City, State, Zip: ______<br>Phone: ______ Fax: ______ |
| **Treatment Information** | **Select Product:** ☐ **OZURDEX™ (dexamethasone intravitreal implant) 0.7 mg Coverage**<br>Diagnosis 1: ______ CPT code 1: ______<br>Diagnosis 2: ______ CPT code 2: ______<br>*we cannot verify benefits without a diagnosis code<br>Date of Service (if scheduled): ______<br>***please note, insurer may take up to 3 weeks to process prior authorization**<br>Place of Service: ☐ Physician's Office ☐ Hosp. Outpt. ☐ Hosp. Inpt.<br>☐ ASC ☐ SNF ☐ Other ______ Dosage: ______ |
| **Prescribing Physician Information** | Physician Name: ______<br>Tax ID#: ______ Specialty ______<br>Facility Name: ______<br>Office Contact Name: ______<br>Address: ______<br>City, State, Zip: ______<br>Phone: ______ Fax: ______<br>Email: ______ NPI: ______ |
| **Insurance Information (Primary Insurer)**<br>☐ Commercial ☐ Medicare<br>☐ Medicaid ☐ Automobile<br>☐ Worker's Compensation<br>☐ CHAMPUS/TRICARE<br>☐ Other: ______ | Name of Insurance Company: ______<br>Address: ______<br>City, State, Zip: ______<br>Phone: ______ Fax: ______<br>Policy Holder's Name: ______ Relationship to Patient: ______<br>Date of Birth: ______ Social Security #: ______<br>Policy/Claim #: ______ Group/Plan #: ______<br>Employer's Name: ______<br>Physician's Provider # (Required for Medicare or Medicaid): ______<br>Physician's participation with the insurer? ☐ Participating ☐ Non-participating |
| **Insurance Information (Secondary Insurer)**<br>☐ Commercial ☐ Medicare<br>☐ Medicaid ☐ Automobile<br>☐ Worker's Compensation<br>☐ CHAMPUS/TRICARE<br>☐ Other: ______ | Name of Insurance Company: ______<br>Address: ______<br>City, State, Zip: ______<br>Phone: ______ Fax: ______<br>Policy Holder's Name: ______ Relationship to Patient: ______<br>Date of Birth: ______ Social Security #: ______<br>Policy/Claim #: ______ Group/Plan #: ______<br>Employer's Name: ______<br>Physician's Provider # (Required for Medicare or Medicaid): ______<br>Physician's participation with the insurer? ☐ Participating ☐ Non-participating |

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