ARBOR ASSISTANCE PROGRAM

P.O. Box 259 ■ Acworth, GA 30101-0259 Telephone:(866) 516-4950, Option 4 ■ Fax: (866) 468-2420
Email: reimbursement@arborpharma.com
Hours: Monday – Friday 8:00 a.m. – 5:00 p.m. EST

GLIADEL® WAFER REIMBURSEMENT SUPPORT FORM

INSTRUCTIONS:

For Insurance Verification/Pre-Certification

1. Please complete all sections of the form.
2. Arbor will respond to the physician's office within 1-2 business days with information regarding verification of insurance and/or pre-certification requirements.

Section 1: DRUG/DIAGNOSIS INFORMATION (required)

Arbor Drug Requested: ❒GLIADEL® WAFER

Known Allergies? ❒ No ❒ Yes, please specify:

Prior Therapy:

Diagnosis: ICD-9 Code(s):

Section 2: PATIENT INFORMATION

U.S. Resident: ❒ Yes ❒ No	Social Security #:	
Phone:	Email:	
Patient Name:	Date of Birth: ___/___/_____	Gender: M ❒ F ❒
Address:	City:	State: Zip:

Section 3: INSURANCE INFORMATION (Attach a copy of the front & back of patient insurance card, Medicare and/or Medicaid cards)

PRIMARY COVERAGE	SECONDARY COVERAGE
Insurance Name:	Insurance Name:
Policy #:	Policy #:
Group #:	Group #:
Policy Holder's Name:	Policy Holder's Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's SSN:	Policy Holder's SSN:
Employer:	Employer:

Section 4: PATIENT CONSENT

The Arbor Assistance Program ("Program") requires us to confirm with you that the patient's consent provides authorization for us to obtain and provide insurance information and for us to contact the insurer and relay patient-related information, e.g., patient's name, date of birth, social security number, diagnosis, insurance information, etc. Does your office have the patient's valid written authorization on file? ❒ **Yes** *If yes, no additional authorization is needed.* ❒ **No** *If no, please have the patient sign a valid written authorization so that you may disclose to the Program information necessary for the Program to provide and obtain information related to this reimbursement issue.*

X Signature of Patient or Patient Representative: _____

Printed Name of Patient OR Legal Representative: _____

(If signed by representative, explain authority to act on behalf of patient): _____

Relationship to Patient:

Section 5: PHYSICIAN INFORMATION

Physician Name:		NPI #:	
State License #:		DEA #	
Practice Name:		Tax ID #	
Address:	City:	State:	Zip:
Office Contact:	Phone:	Fax:	Email:

Section 6: PHYSICIAN CERTIFICATION

Please indicate that you agree to these terms by signing below. Failure to comply with these terms may mean you (and any patients you treat) will not be eligible to participate in the Arbor Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

X Physician's Signature: _____ **Date:** _____

Arbor cannot guarantee payment of any claim. Coding, coverage, and reimbursement may vary significantly by payer, plan, patient, and setting of care. Actual coverage and reimbursement decisions are made by individual payers following the receipt of claims. For additional information, customers should consult with their payers for all relevant coding, reimbursement, and coverage requirements. It is the sole responsibility of the provider to select the proper code and ensure the accuracy of all claims used in seeking reimbursement. All services must be medically appropriate and properly supported in the patient medical record.