

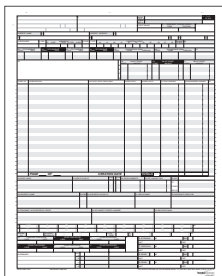
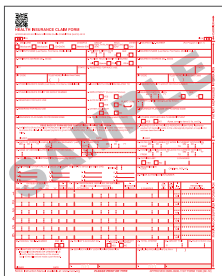


Oncology and Transplant
Patient Support by Sanofi Genzyme

A guide to reimbursement through the CareASSIST Copay Program

Submitting claims through the CareASSIST Copay Program

In order for your patient to be reimbursed, your office must submit the following to CareASSIST on your patient's behalf:



Date of Service: 08/15/2019			
Bill#	08/15/2019	08/15/2019	
Client Name	Richard Roe	Richard Roe	
Provider Name	Jane Doe	Jane Doe	
DOB	08/15/2019	08/15/2019	
CPT1	99211	99211	
Units	1	1	
Charge	100.00	100.00	
Page	Healthcare Group, Inc.	Healthcare Group, Inc.	
Method	SD	SD	
Status	Submitted	Submitted	
Total Service Lines: 1		Total Charge: 100.00	

Date of Service: 08/15/2019			
Bill#	08/15/2019	08/15/2019	08/15/2019
Client Name	Richard Roe	Richard Roe	Richard Roe
Provider Name	Jane Doe	Jane Doe	Jane Doe
DOB	08/15/2019	08/15/2019	08/15/2019
CPT1	99211	99211	99211
Units	1	1	1
Charge	100.00	100.00	100.00
Page	Healthcare Group, Inc.	Healthcare Group, Inc.	Healthcare Group, Inc.
Method	SD	SD	SD
Status	Submitted	Submitted	Submitted
Total Service Lines: 3		Total Charge: 300.00	



Either a CMS-1500 or a UB-04

Date of service (DOS)

Explanation of Benefits (EOB)

Mail or fax all forms to CareASSIST



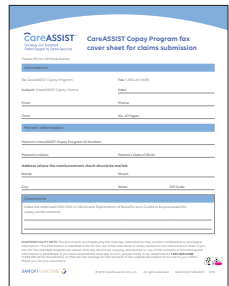
Mail
CareASSIST by Sanofi Genzyme
PO Box 220616
Charlotte, NC 28222



Fax
1-855-411-9689

When submitting claims by fax, please use the CareASSIST Copay Program fax cover sheet for claims submission

Fill out all fields on the fax cover sheet and be sure to include the following information:



- Your patient's CareASSIST Copay Program ID number
- Your patient's initials
- Your patient's date of birth
- The address where the reimbursement check should be mailed

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A guide to reimbursement through the CareASSIST Copay Program (cont'd)

Considerations when submitting claims through the CareASSIST Copay Program



The CareASSIST Copay Program will **disburse funds in approximately 7 to 14 business days** after all materials are reviewed and approved



You **must not** have received any **payment from the patient or other third party** for the copay amount



All requests for reimbursement must be **submitted within 120 days of the DOS**

For more information about reimbursement through the CareASSIST Copay Program, call **1-833-WE+CARE** (1-833-930-2273), Mon – Fri, 9 AM – 8 PM ET, or visit SanofiCareAssist.com/hcp

