



CareASSIST Copay Program fax cover sheet for claims submission

Please fill out all fields below.

Information

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|----------------------------------|---------------------|
| To: CareASSIST Copay Program | Fax: 1-855-411-9689 |
| Subject: CareASSIST Copay Claims | Date: _____ |
| From: _____ | Phone: _____ |
| Time: _____ | No. of Pages: _____ |

Patient information

Patient's CareASSIST Copay Program ID Number: _____

Patient's Initials: _____ Patient's Date of Birth: _____

Address where the reimbursement check should be mailed:

Name: _____ Street: _____

City: _____ State: _____ ZIP Code: _____

Comments

Index the attached CMS-1500 or UB-04 and Explanation of Benefits as a CLAIM to be processed for copay reimbursement.

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