CareASSIST®
Patient Support by Sanofi Genzyme

CareASSIST Copay Program fax cover sheet for claims submission

Please fill out all fields below.

Information

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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