



**Eisai Assistance Program
INSURANCE VERIFICATION FORM**
Please fax completed form to 866-573-4724

**Hours: Monday - Friday
8:00 a.m. – 8:00 p.m. EST**
Phone: 866-61-EISAI (866-613-4724)

INSTRUCTIONS

For Insurance Verification/Pre-Certification

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

DRUG/DIAGNOSIS INFORMATION (Required)

Eisai Drug Requested: (Select only one) Aloxi® administered with (list all chemo agents) _____
 Halaven™ Dacogen® Ontak® Targretin® gel Targretin® capsules Hexalen® Panretin® Gliadel®
 Strength: _____ Prior Therapy: _____
 Diagnosis: _____ ICD-9 Code(s): _____
 Known Allergies? No Yes, please specify: _____

PATIENT INFORMATION (Please print)

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

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

PRIMARY COVERAGE		SECONDARY COVERAGE	
Insurance Name:		Insurance Name:	
Insurance Phone #:		Insurance Phone #:	
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:	
Payer Specific Provider # or PTAN (if applicable)		Payer Specific Provider # or PTAN (if applicable)	

PATIENT CONSENT

The Eisai 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 facility 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 _____ Date _____
 Signature of Patient or Patient Representative
 _____ (If signed by representative, explain authority to act on behalf of patient) Relationship to Patient
 Printed Name of Patient OR Legal Representative

PHYSICIAN/FACILITY INFORMATION (Please print and ensure all ID #s correspond to the GROUP or PROVIDER)

Physician Name: _____ NPI #: _____
 Facility Name: _____
 Address: _____ City: _____ State: _____ ZIP: _____
 Phone: _____ Fax: _____ Office Contact: _____
 Tax ID: _____ State License No: _____

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 Eisai Assistance Program. Your signature confirms that there is a valid medical need for this patient's prescription.

 Physician's Signature: _____ Date: _____

Eisai 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.