

# GSK Reimbursement Resource Center – Benefit Verification Request Form

Patients or healthcare professionals requesting patient-specific verification of benefits for GlaxoSmithKline products, should mail or fax this signed and completed request form to 866-216-5292 with a copy of the patient's health insurance and prescription drug cards (front and back). Patient benefits will be researched and communicated back to you within two business days, or as soon as possible following receipt of information from the payer. **IMPORTANT: Patients must sign and return the attached *Patient Authorization to Release and Disclose Medical Information* before we can initiate patient-specific research.**

*Please check the appropriate box to indicate who is requesting this information. Results will be sent to the requester.*  
*Patient*  *-or-* *Physician/Prescriber/Healthcare Professional*

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Daytime Telephone: \_\_\_\_\_ Evening Telephone: \_\_\_\_\_  
Best Time to Call: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

## Insurance Information

Primary Insurer: \_\_\_\_\_ Secondary Insurer (if applicable): \_\_\_\_\_  
Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Policy ID Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
Subscriber Date of Birth: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

## Treatment Information

GSK Drug/Biological Name: \_\_\_\_\_ Primary Diagnosis: \_\_\_\_\_ ICD-9-CM: \_\_\_\_\_ . \_\_\_\_\_  
Dose: \_\_\_\_\_ Strength: \_\_\_\_\_ Form: \_\_\_\_\_ Rx Directions: \_\_\_\_\_  
Previous Treatments (if applicable): \_\_\_\_\_

***Please indicate setting of care for physician-administered products:***

Physician Office  Freestanding Facility  Outpatient Hospital  Inpatient Hospital  Other : \_\_\_\_\_  
▪ Who is purchasing the drug/biological? \_\_\_\_\_  
▪ Who is billing for the drug/biological? \_\_\_\_\_  
▪ Anticipated treatment dates: \_\_\_\_\_

## PHYSICIAN/PRESCRIBER INFORMATION

Physician/Prescriber Name: \_\_\_\_\_ Facility Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Tax ID #: \_\_\_\_\_ National Provider Identifier #: \_\_\_\_\_

**Payer-Specific Provider # (healthcare professionals only):**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

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1-800-745-2967

reimbursement.gsk.com

**GSK REIMBURSEMENT RESOURCE CENTER**

**Patient Authorization to Release and Disclose Medical Information**

IMPORTANT: The patient, or the patient’s authorized representative, MUST sign this form in order to receive assistance from the GSK Reimbursement Resource Center (the “RRC”). Before signing, the patient, or the patient’s authorized representative, if any, must review, understand and agree to the disclosure and release. If an authorized representative signs for the patient, such authorized representative must indicate his/her specific relationship to the patient.

By my signature I authorize GlaxoSmithKline, as well as The Lash Group, Inc., and any other companies that GlaxoSmithKline uses to administer the RRC to do the following:

- 1) Request and receive from my doctor, healthcare provider, health insurer or pharmacist information necessary to investigate and resolve my coverage, coding or reimbursement inquiry.
- 2) Use and disclose to each other any information that I provide to the RRC for the purpose of investigating and resolving my coverage, coding or reimbursement inquiry or to administer the RRC.
- 3) Disclose to my treating physician, health care professional or pharmacist information provided to the RRC when necessary to resolve my coverage, coding or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, or pharmacist to release information about my prescribed medications and medical condition requested by GlaxoSmithKline and Lash Group.
- 4) Contact my insurer, other potential funding sources, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information about my prescribed medications and medical condition that has been provided by my physician, healthcare provider, or pharmacist.
- 5) Disclose any information obtained from the sources listed above to third parties if required by law.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Authorization to Release and Disclose Medical Information.

I understand that once information about me is provided to the RRC based on this authorization, federal privacy laws may not prevent the RRC from further disclosing my information. However, I understand that the RRC has agreed that it will only use or disclose information it receives for the purposes described in this authorization or as required by law.

I understand that this Authorization to Release and Disclose Medical Information will remain in effect for 180 days or until my coverage, coding, or reimbursement inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 1-800-745-2967, and mailing a signed written statement of my revocation to the RRC at the address below, but that such a revocation would end my eligibility to participate in the RRC. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on the authorization. This means that, after you revoke the authorization, your information may be disclosed among GSK and the company or companies that help GSK administer the RRC in order to maintain records of your participation, but it will not be otherwise disclosed or used.

\_\_\_\_\_  
Patient name (print)

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

Relationship if other than patient: \_\_\_\_\_

**GSK Reimbursement Resource Center  
P.O. Box 221425  
Charlotte, NC 28222-1425  
800-745-2967 phone  
866-216-5292 fax  
reimbursement.gsk.com**