

*Required information

DURYSTA™ SAVINGS PROGRAM PHYSICIAN REIMBURSEMENT REQUEST FORM

Thank you for using the DURYSTA™ Savings Program. In order to process reimbursement, please complete this form within 180 days from date of service and upload to AllerganEyeCue.com or fax it, along with the required supporting documentation listed at the bottom of this page, to 1-866-676-4069. If your patient qualifies, estimated time for reimbursement is 3 days (ACH) or 2 to 4 weeks (check).

PATIENT

Patient first name*: _____ Patient last name*: _____ Date of birth*: ____/____/____

Patient Member ID*: _____

This is the number you receive after enrollment.

PHYSICIAN

Reimbursement checks will be mailed to the address on the Explanation of Benefits (EOB); not applicable to ACH payment.

Physician first name*: _____ Physician last name*: _____

Office contact email address*: _____

†For fax users only: Please indicate payment preference type for claims reimbursement:

Electronic payment via ACH Check

†Note: Registered portal users with an indicated payment preference in their account profile will receive reimbursement based on the selected method.

SUPPORTING DOCUMENTS TO INCLUDE

- Completed DURYSTA™ Savings Program Physician Reimbursement Request form (this form)
- HCFA 1500 form
- EOB document(s): Should be obtained from the patient's insurer

COPY ATTESTATION

I, _____
Physician's or delegate's name*

hereby attest that I am the prescribing physician or a delegate authorized to sign on behalf of the prescribing physician and that the patient listed above, on _____,
Date of service*

administration. I also attest that, to the best of my knowledge, the patient listed above has not had a prior administration of DURYSTA™ in the treated eye. I also attest that all appropriate steps were completed to determine the appropriate copay for my patient and that the information submitted to Allergan EyeCue® is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of data may be subject to certain fines and/or liabilities. I understand that this information will be used for operational purposes as part of the DURYSTA™ Savings Program from Allergan.

PHYSICIAN OR DELEGATE SIGNATURE (REQUIRED)

Physician or delegate signature* _____ Date* _____

**Complete and upload all materials to AllerganEyeCue.com or fax to 1-866-676-4069.
Questions? Contact our Help Desk at 1-833-DURYSTA, option 2 or visit AllerganEyeCue.com.**