**Pharmacy Claim Reimbursement Form** **Tel: 1.800.364.4767**

Complete this form and submit with the required receipts to be considered for rebate.

## Patient Information

**Name** (Last, First): _____, _____

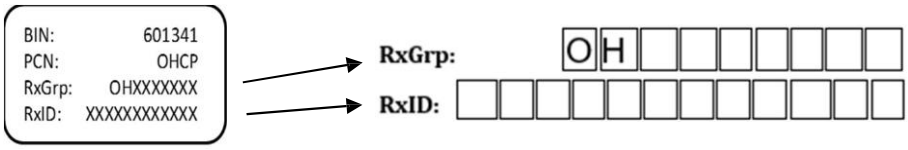
**Address** (Street): _____ **Date of Birth:** ☐☐-☐☐-☐☐

**Apt./Suite No.** _____ **City:** _____ **State:** ☐☐ **Zip:** ☐☐☐☐☐-☐☐☐☐

**Email:** _____@_____ **Phone:** (  ) _____-_____ **Fax:** (  ) _____-_____

(Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.)

Please provide this information found on your Savings Card, it will look similar to the example shown (right).




[ ] Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.

## Pharmacy Documents

Mail this completed form along with the following items to the following address:

**Attn: Claims Processing Department, IQVIA, Inc.**
**430 Mountain Ave., Suite 105, New Providence, NJ 07974**

RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 OFI
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE,NY 11788
AA0000000 (631)582-6787
RxPrice:$XXX.XX
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

**Please be sure to include all of the following to avoid claim rejection or delay:**

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information:
   - ✓ Patient name and address
   - ✓ Pharmacy name, address, and phone
   - ✓ Doctor or health care provider name, address, and phone number
   - ✓ Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
   - ✓ Overall prescription price and Copay amount/out of pocket expense paid
2. A receipt (register, pharmacy, explanation of benefits, or other) that clearly identifies the amount paid for this prescription.
3. Copy of your primary insurance card (including both front and back of the card)

## Certification Statement

I, _____, certify that I am self-insured or have commercial insurance and the information provided in this claim is complete and accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state or federally funded) program and that my insurance provider does not prohibit participation in this program. I understand and accept the terms and conditions for participation in this program and understand that I am liable for any misrepresentations herein to the full extent of applicable law.

Claimant/Patient/Legal Guardian Signature: _____ Date_____

## Eligibility and Privacy Notice

Please see eligibility criteria in the accompanying letter. For information on how we collect and process your personal data, including the categories we collect, purposes for their rebate, and disclosures to third parties, visit https://abbv.ie/PrivacyPatient. Through my submission of the enrollment form, I consent to the collection, use, and disclosure of my personal health data, as described in the Privacy Notice above and in AbbVie's Privacy Notice in the "How We May Disclose Personal Data" section. My consent is required to process sensitive personal data under certain privacy laws, and I have the right to withdraw my consent by visiting "Your Privacy Choices" on AbbVie's website.

**Please allow 1 – 2 weeks for processing. This form can be used for multiple submissions.**
**For assistance completing this form, contact IQVIA at 1-800-364-4767 and select the Patients option.**

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