Pfizer Vaccines

REIMBURSEMENT SUPPORT SERVICES

PHONE
1-866-744-3198

FAX
1-866-744-3303

Monday–Friday 8:00 AM–8:00 PM (Eastern Time)

Pfizer

PFIZER VACCINES REIMBURSEMENT SUPPORT SERVICES CAN ASSIST YOUR PATIENTS BY CONDUCTING BENEFITS INVESTIGATIONS AND PROVIDING CODING ASSISTANCE

Request a benefits investigation via phone or fax

CALL

To obtain a copy of the Benefits Verification Request form, call your Pfizer Vaccines Specialist or call the Hotline directly

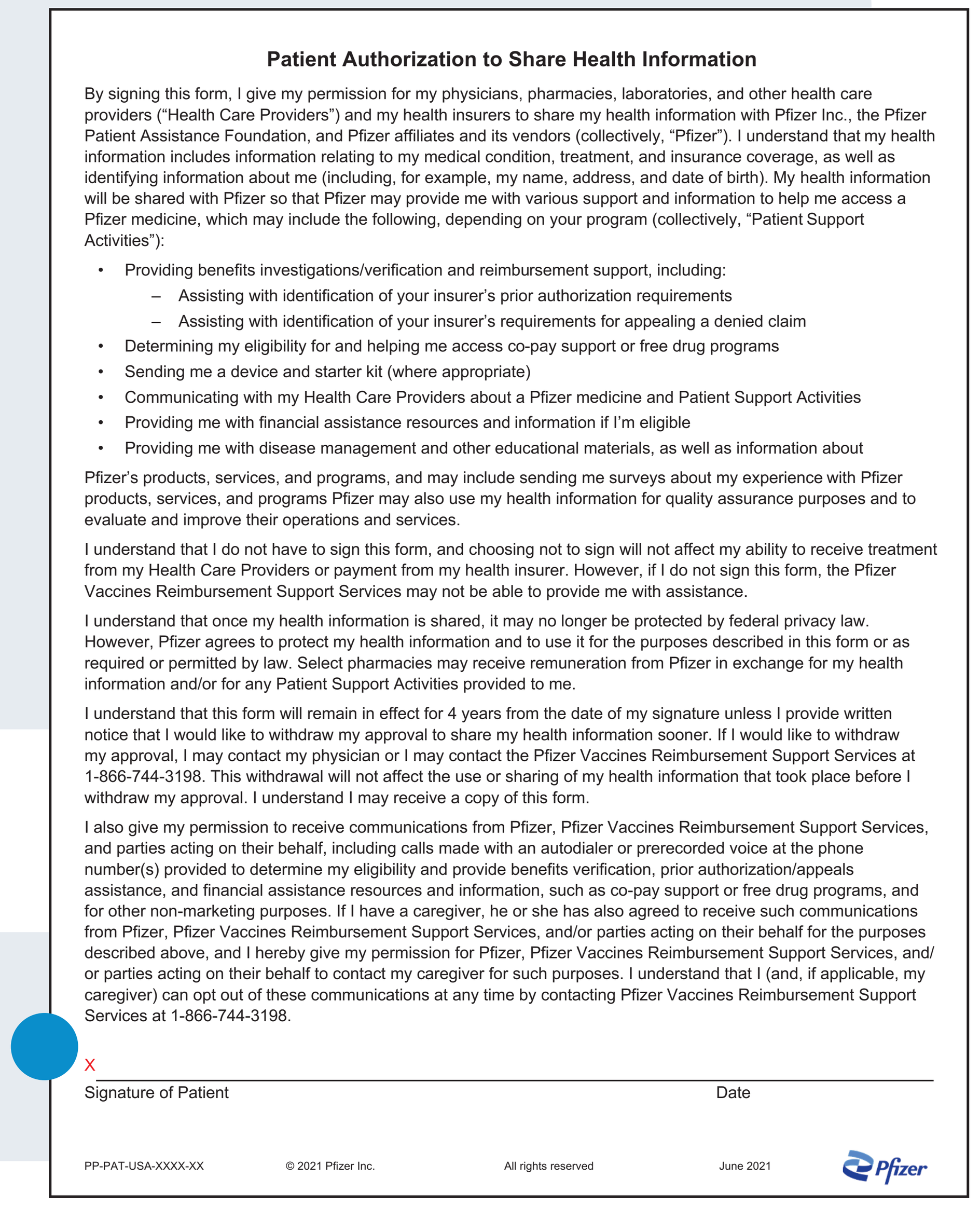
FAX

Complete, sign, and fax the form to **1-866-744-3303**

Additional billing and coding information is available by calling **1-866-744-3198**,
Monday–Friday 8:00 am–8:00 pm (Eastern Time)

Helpful tips for filling out the benefits verification request form

1 If you don't already have a HIPAA Authorization on file for your patient, have your patient review and sign the second page of the form and retain for your records.



Patient Authorization to Share Health Information

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other health care providers ("Health Care Providers") and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, and Pfizer affiliates and its vendors (collectively, "Pfizer"). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program (collectively, "Patient Support Activities"):

- Providing benefits investigations/verification and reimbursement support, including:
  - Assisting with identification of your insurer's prior authorization requirements
  - Assisting with identification of your insurer's requirements for appealing a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Health Care Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I'm eligible
- Providing me with disease management and other educational materials, as well as information about

Pfizer's products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs Pfizer may also use my health information for quality assurance purposes and to evaluate and improve their operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive treatment from my Health Care Providers or payment from my health insurer. However, if I do not sign this form, the Pfizer Vaccines Reimbursement Support Services may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact the Pfizer Vaccines Reimbursement Support Services at 1-866-744-3198. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, Pfizer Vaccines Reimbursement Support Services, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, Pfizer Vaccines Reimbursement Support Services, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, Pfizer Vaccines Reimbursement Support Services, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting Pfizer Vaccines Reimbursement Support Services at 1-866-744-3198.

X ______________________________
Signature of Patient   Date

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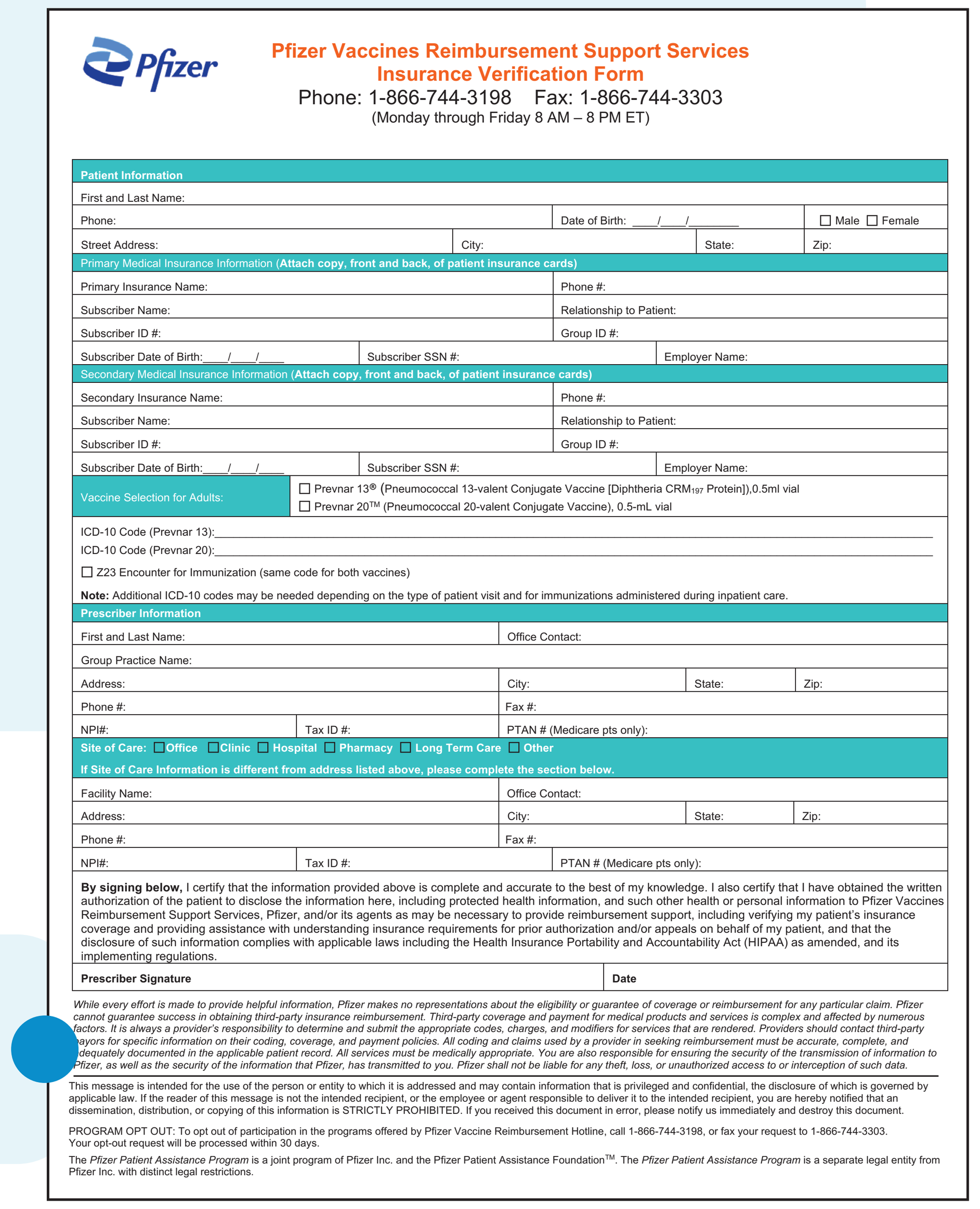
Retain in patient's record

2 Be sure to fully complete and sign the form. If the patient has secondary insurance, be sure to provide this information. Also, be sure that the site of care section is complete.



Pfizer Vaccines Reimbursement Support Services
Insurance Verification Form
Phone: 1-866-744-3198   Fax: 1-866-744-3303
(Monday through Friday 8 AM – 8 PM ET)

Patient Information
First and Last Name:
Phone: Date of Birth: ____/____/________   ☐ Male ☐ Female
Street Address: City: State: Zip:

Primary Medical Insurance Information (**Attach copy, front and back, of patient insurance cards)**
Primary Insurance Name: Phone #:
Subscriber Name: Relationship to Patient:
Subscriber ID #:   Group ID #:

Fax to Pfizer Vaccines Reimbursement Support Services

  August 2021 Pfizer