

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 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.

Retain in patient's record

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.

Signature of Patient Date

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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.

Fax to Pfizer Vaccines Reimbursement Support Services

Pfizer 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: _____ Date of Birth: ____/____/____ Male Female

Phone: _____ City: _____ State: _____ Zip: _____

Primary Medical Insurance Information (Attach copy, front and back, of patient insurance card)

Primary Insurance Name: _____ Phone #: _____
Subscriber Name: _____ Relationship to Patient: _____
Subscriber ID #: _____ Group ID #: _____
Subscriber Date of Birth: ____/____/____ Subscriber SSN #: _____ Employer Name: _____

Secondary Medical Insurance Information (Attach copy, front and back, of patient insurance card)

Secondary Insurance Name: _____ Phone #: _____
Subscriber Name: _____ Relationship to Patient: _____
Subscriber ID #: _____ Group ID #: _____
Subscriber Date of Birth: ____/____/____ Subscriber SSN #: _____ Employer Name: _____

Vaccine Selection for Adults: Pfizer 13^v (Pneumococcal 13-valent Conjugate Vaccine Diphtheria Clostridium Pertussis) 0.5ml vial
 Pfizer 23^v (Pneumococcal 23-valent Conjugate Vaccine) 0.5 ml vial

ICD-10 Code (Pfizer 13): _____
ICD-10 Code (Pfizer 23): _____
 Z23 Encounter for immunization (name code for both vaccines)

Note: Additional ICD-10 codes may be needed depending on the type of patient visit and for immunizations administered during inpatient care.

Physician Information

First and Last Name: _____ Office Contact: _____
Group Practice Name: _____ City: _____ State: _____ Zip: _____
Address: _____
Phone #: _____ Fax #: _____
Name: _____ Title: _____ (Pfizer # Medicare ID #: _____)

Site of Care Information (If Office, Clinic, Hospital, Pharmacy, Long Term Care, or Shelter)

If Site of Care Information is different from address listed above, please complete the section below.

Facility Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____
NPI #: _____ Tax ID #: _____ PTAN # (Medicare ID #: _____)

By signing below, I certify that the information provided above is complete and accurate to the best of my knowledge. I also certify that I have obtained the written authorization of the patient to disclose the information here, including protected health information, and such other health or personal information to Pfizer Vaccines Reimbursement Support Services, Pfizer, and/or its agents as may be necessary to provide reimbursement support, including verifying my patient's insurance coverage and providing assistance with understanding insurance requirements for your authorization and/or appeals on behalf of my patient, and that the disclosure of such information complies with applicable laws including the Health Insurance Portability and Accountability Act (HIPAA) as amended, and its implementing regulations.

Prescriber Signature: _____ Date: _____

While every effort is made to provide helpful information, Pfizer makes no representation about the eligibility or guarantee of coverage or reimbursement for any particular claim. Pfizer cannot guarantee access to obtaining their prior vaccine reimbursement. Third-party coverage and payment for medical products and services is complex and affected by numerous factors, including insurance coverage, and patient portals. All coding and claims used by a provider or seeking reimbursement must be accurate, complete, and fully compliant with applicable laws and regulations. You are also responsible for ensuring the accuracy of the information provided to Pfizer, as well as the accuracy of the information that Pfizer has transmitted to you. Pfizer shall not be liable for any net loss, or unauthorized access to or interception of such data.

This message is intended for the use of the recipient to which it is addressed and the content hereof may be privileged and confidential. The disclosure of which is prohibited by applicable law. If the holder of this message is not the intended recipient, or the addressee or agent responsible to deliver it to the intended recipient, you are hereby notified that an unauthorized disclosure or copying of the contents of this message is STRICTLY PROHIBITED. If you received this document in error, please notify us immediately and delete this document.

PROGRAM OPT-OUT: To opt out of participation in the programs offered by Pfizer Vaccines Reimbursement Hotline, call 1-866-744-3198, or for your request to 1-866-744-3303. Your request must be processed within 30 days.

The Pfizer Patient Assistance Program is a part program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Program is a separate legal entity from Pfizer Inc. with distinct legal restrictions.

