FAX

Attention: Truveris
Fax Number: 1-347-630-0347
Number of pages:

Ozurdex® (dexamethasone intravitreal implant) 0.7 mg

OZURDEX® Savings Program
Physician Reimbursement Request

Thank you for using the OZURDEX® Savings Program. In order to process reimbursement, please complete this form and fax it, along with the required supporting documentation listed at the bottom of this page, to 1-347-630-0347. If your patient qualifies, you should receive a check in the mail in 4 to 6 weeks.

PATIENT INFORMATION

Patient Member ID:_____
This is the number the patient receives after enrollment and provides to you.

Email address:_____ Telephone:_____

PHYSICIAN INFORMATION

Reimbursement check will be mailed to the address provided.

First name:_____ Last name:_____

Practice name:_____ Address:_____

City:_____ State:_____ Zip code:_____

Email address:_____ Telephone:_____

SUPPORTING DOCUMENTS TO INCLUDE IN FAX:

- HCFA 1500 form
- Explanation of Benefits document(s): Should be obtained from the patient's insurer
- Signed Physician Attestation Form OR Purchase Charge Documentation: This is the receipt your office provides to the patient for paying their co-pay for OZURDEX®

Fax all materials to: 1-347-630-0347

Questions? Contact our Help Desk at 1-855-454-6369 or visit OzurdexSavingsProgram.com