Insurance Verification Assistance

- Offers help in verifying patients' benefits and determining specific insurers' coverage guidelines
- Assists in identifying and complying with prior authorization guidelines
- Is available to providers, administrators, and patients

How the Process Works

Step 1: Patient completes the Insurance Verification Request Form (included on back) and signs the Authorization to Disclose Health Information Form.

Step 2: Provider, patient, or administrator faxes the Insurance Verification Request Form to Nplate™ (romiplostim) NEXUS Program at 1-888-508-8090.

Step 3: Nplate™ NEXUS Program contacts insurer and documents summary of coverage, available distribution channels, co-pay requirements,deductibles, and prior authorizations.

Step 4: Nplate™ NEXUS Program faxes patient insurance verification report to provider.

Nplate™ (romiplostim) NEXUS Program

Network of EXperts Understanding and Supporting Nplate™ and patients

1-877-Nplate1 (1-877-675-2831) www.Nplate.com

Nplate™ NEXUS Program
1-877-Nplate1 (1-877-675-2831) telephone; 1-888-508-8090 fax
www.Nplate.com

Insurance Verification Request Form for Nplate™ (romiplostim)

Please complete this form and fax it to 1-888-508-8090 for processing.

Please confirm that this form is completed and faxed successfully to ensure timely completion of the research.

TREATING PHYSICIAN/FACILITY INFORMATION

Contact/Requestor Name ____________________

Facility Name ____________________ National Provider ID # ____________________

Phone # (_____) ____________________ Fax # (_____) ____________________

Treating Physician's Name ____________________ State License # ____________________

Address ____________________ Tax ID # ____________________

City, State, Zip ____________________ Physician Specialty ____________________

REQUESTOR PREFERENCES Please check all settings of care you would like researched:

☐ Physician Office ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ Other ____________________

How would you prefer results relayed ? ☐ Phone ☐ Fax ☐ No preference

PATIENT INFORMATION

Patient First Name ____________________ Last Name ____________________

Patient DOB ________/________/________ (mm/dd/yy) Patient State & Zip Code ____________________

Social Security # ________-________- ________ Patient Phone Number ____________________

PATIENT MEDICAL AND TREATMENT INFORMATION

Diagnosis Code (please include ICD-9 code/s): ____________________

Setting of Service ☐ Physician Office ☐ Hospital Inpatient ☐ Hospital Outpatient Other ____________________

PRIMARY INSURANCE If Medicaid, please include the Medicaid provider

Insurer Name ____________________ Relationship to patient ____________________

Insurer State ____________________ Insurer Phone Number (____)________-____________

Insurer Fax Number (____) _______ - ____________________ Provider # for this Policy ____________________

Policyholder's Name ____________________

Policy Number ____________________ Policyholder's SSN ________-________- ________

Group/Plan Number ____________________ Policyholder's DOB ____________________

SECONDARY INSURANCE If Medicaid, please include the Medicaid provider

Insurer Name ____________________ Relationship to patient* ____________________

Insurer State ____________________ Insurer Phone Number (_________)____________________

Insurer Fax Number (_________) ____________________ Provider # for this Policy ____________________

Policyholder's Name* ____________________ Policyholder's Phone #* (_________) ____________________

Policy Number ____________________ Policyholder's SSN* ________-________- ________

Policyholder's DOB* ____________________ Group/Plan Number ____________________

Employer's Name ____________________

This verification of benefits is not a guarantee of payment by the payor, but is deemed as current coverage information as relayed by the payor to Nplate™ NEXUS.

This verification cannot take the place of written policy information from the payor.

***Complete only if different from primary insurance information.**

© 2008 Amgen All rights reserved. MCxxxxx 600/6-07 Pxxxxx