ARC of Support® Reimbursement Services
ABRAXANE® Benefit Verification Request Form
800.564.0216, Option3

To verify your patient's benefits for ABRAXANE® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension) (albumin bound) please complete each section to the fullest extent possible. **Fax completed request to ARC of Support® Reimbursement Services at (866) 242-4141.** You will receive your patient's ABRAXANE® coverage information faxed to you within 2 business days.

This form can also be submitted online. Go to http://www.abraxane.com/professional/reimbursement.aspx and scroll down the page to the ABRAXANE® Benefit Verification Request Form titled *"on-line submission"*.

SECTION 1 - PHYSICIAN INFORMATION

Physician Name:	State License #:	DEA #
Name of Group/Hospital:	Tax ID #:	NPI:
Correspondence Address:		
City:	State:	Zip:
Office Contact Name:	Phone: ( )	Extension:
Shipping Address *(if different than above)*		Fax: ( )
City:	State:	Zip:
Treatment Start Date:		

SECTION 2 - PATIENT INFORMATION

First Name:	Last Name:	
Correspondence Address:		
City:	State:	Zip:
SSN: - -	Date of Birth: / /	Telephone: ( )

PATIENT MEDICAL INFORMATION

Diagnosis/ ICD-9-CM:	Dosing:	Dosing Schedule:
Is the cancer metastatic?	Treatment history:	

SECTION 3 – HEALTH INSURANCE INFORMATION

Primary Insurance Company Name			
Phone Number	( )	SSN	
Policy Number		Group Number	
Policy Holder's Name *(if different than patient)*		DOB	/ /
Secondary Insurance Company Name			
Policy Number		Group Number	
Policy Holder's Name *(if different than patient)*		DOB	/ /
Telephone Number	( )	SSN	

SECTION 4 – PATIENT CONSENT

ARC of Support® Reimbursement Services must have the patient's consent to contact the insurance company to conduct benefit research. If we have your consent, please sign below.

Patient's Signature:_____ Date:_____

Or, if this benefit verification is requested by the physician: ARC of Support® Reimbursement Services must have your patient's consent to share this medical information. If you have the patient's written consent to release this information on file, please sign below.

Physician Representative Signature: _____ Date:_____

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