# 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 #: | |
| Subscriber Date of Birth:____/____/____ | Subscriber SSN #: | Employer Name: |

| **Secondary Medical Insurance Information** (Attach copy, front and back, of patient insurance cards) | | |
|---|---|---|
| Secondary Insurance Name: | Phone #: | |
| Subscriber Name: | Relationship to Patient: | |
| Subscriber ID #: | Group ID #: | |
| Subscriber Date of Birth:____/____/____ | Subscriber SSN #: | Employer Name: |

| **Pharmacy Insurance Information (Attach copy, front and back, of patient insurance cards)** | | | |
|---|---|---|---|
| Subscriber ID: | Bin: | PCN: | Group ID: |

| | |
|---|---|
| **Vaccine Selection for Adults:** | ☐ Prevnar 20™ (Pneumococcal 20-valent Conjugate Vaccine), 0.5-mL vial<br>☐ ABRYSVO™ (Respiratory Syncytial Virus Vaccine), Single-dose carton<br>☐ PENBRAYA™ (Meningococcal Groups A, B, C, W, and Y Vaccine)<br>☐ COMIRNATY® (COVID-19 Vaccine, mRNA) suspension for injection<br>☐ Trumenba® (meningococcal group B vaccine) Injection Rx |

ICD-10 Code:_____

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

| **Prescriber Information** | | | |
|---|---|---|---|
| First and Last Name: | Office Contact: | | |
| Group Practice Name: | | | |
| Address: | City: | State: | Zip: |
| Phone #: | Fax #: | | |
| NPI#: Tax ID #: | PTAN # (Medicare pts only): | | |

**Site of Care:** ☐ **Office** ☐ **Pharmacy** ☐ **Hospital** ☐ **Clinic** ☐ **Long Term Care** ☐ **Other:** _____

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

| | | | |
|---|---|---|---|
| Pharmacy/Facility Name: | Contact Name: | | |
| Address: | City: | State: | Zip: |
| Phone #: | Fax #: | | |
| NPI#: Tax ID #: | PTAN # (Medicare pts only): | | |

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including, assisting the patient with benefits verification, prior authorization/appeals assistance, for which the patient may be eligible, and other support for the Pfizer Vaccines listed above.

I give my permission to receive calls related to these services from Pfizer, Pfizer Vaccine Reimbursement Support Services, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

| **Prescriber Signature** | **Date** |
|---|---|

*While every effort is made to provide helpful information, Pfizer makes no representations about the eligibility or guarantee of coverage or reimbursement for any particular claim. Pfizer cannot guarantee success in obtaining third-party insurance reimbursement. Third-party coverage and payment for medical products and services is complex and affected by numerous factors. It is always a provider's responsibility to determine and submit the appropriate codes, charges, and modifiers for services that are rendered. Providers should contact third-party payors for specific information on their coding, coverage, and payment policies. All coding and claims used by a provider in seeking reimbursement must be accurate, complete, and adequately documented in the applicable patient record. All services must be medically appropriate. You are also responsible for ensuring the security of the transmission of information to Pfizer, as well as the security of the information that Pfizer, has transmitted to you. Pfizer shall not be liable for any theft, loss, or unauthorized access to or interception of such data.*

**Please see full Prescribing Information for Prevnar 20 (prevnar20.com), ABRYSVO (abrysvo.com), Trumenba (trumenba.com), COMIRNATY (comirnaty.com) and PENBRAYA (penbraya.com)**


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**HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (*= required field) FOR PATIENTS †**

I authorize (i.e., allow) the use and/or disclosure of my Protected Health Information, described below, which is protected under a federal law known as the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). In general, Protected Health Information is information, including demographic information, which (1) relates to my past, present, or future physical or mental health or condition, the provision of health care to me, or the past, present, or future payment for the provision of health care to me, and (2) that identifies me or for which there is a reasonable basis to believe can be used to identify me. I understand that this authorization is voluntary.

1. **Person(s) or Class of Person(s) Authorized to Disclose Protected Health Information:** My health care providers, including my treating physicians and medical laboratories, that provide health care to me and conduct medical testing.

2. **Person(s) or Class of Person(s) Authorized to Receive Protected Health Information:** Pfizer Inc. ("Pfizer"), Pfizer affiliates, and other authorized service providers of Pfizer.

3**. Description of Protected Health Information that may be Used and/or Disclosed:** My name, patient identifier, test results, medical records, healthcare provider information, other data that identifies that I am seeking health care services, and data otherwise related to my health condition, diagnosis, and/or treatment.

4. **Purpose(s) for the Use and/or Disclosure of Protected Health Information:** To determine whether conditions for eligibility under the Program have been met; and to provide me with various support to help me access a Pfizer medicine, which may include the following: Providing benefits investigations/verification and reimbursement support, including:

• Assisting with identification of my insurer's prior authorization requirements

• Assisting with identification of my insurer's requirements for appealing a denied claim

• Determining my eligibility for and helping me access copay support or free drug programs • Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities

• Providing me with financial assistance resources and information if I'm eligible

• Pfizer also may use my health information for quality assurance purposes and to evaluate and improve their operations and services

5. **No Conditioning.** I understand that my treatment, enrollment, eligibility and payment under my health plan are not conditioned upon me signing this form and agreeing to permit the disclosure of my Protected Health Information to Pfizer and its authorized service providers.

6. **Right to Revoke.** I may revoke (i.e., take back) this authorization at any time, except to the extent that my health care providers have taken any action in reliance on my authorization. I understand that if I revoke this authorization, it will not have any effect on any uses or disclosures of my Protected Health Information that occurred prior to receiving my revocation. To revoke, I understand that I must notify Pfizer Vaccines Reimbursement Support Services at 1-866-744-3198.

7. **Expiration of Authorization.** This authorization will remain in full force and effect for two years from the date of this authorization, unless I revoke it prior to this time.

8. **Potential for Re-disclosure.** Persons or entities that receive my Protected Health Information under this authorization may not be required by privacy laws (such as HIPAA) to protect the information and they may share it with others without my permission, if permitted by laws that are applicable to them.

9. **Copy of Authorization.** I understand that I am entitled to receive a signed copy of this authorization. I have read this authorization and/or had its contents read to me. I authorize the use and disclosure of my Protected Health Information as described in 1–9 above.

SIGN X _____ _____ _____

Patient or patient representative signature* (must be 18 years or older)† Patient or patient representative name (please print)‡ Date*

If signed by patient representative, you must indicate below the authority to act on behalf of patient§ :

■ Court Appointed ■ Parent/Guardian ■ Power of Attorney, including authority to make healthcare decisions ■ Other

†Patients who are 18 years or older must sign unless incapacitated; otherwise, a representative with one of the legal authorities noted below can sign on their behalf.

‡ NOT required if patient signs.

§ Required if patient representative signs.

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