injectafer® ferric carboxymaltose injection

IV Iron Reimbursement Hotline
Insurance Verification Request Form

Phone: (877) 4-IV-IRON
Fax: 888-354-4856

PLEASE COMPLETE ALL SECTIONS AND FAX TO: 888-354-4856. IV Iron Reimbursement Hotline will contact the insurance company or companies listed below to determine coverage for Injectafer® as requested.

Name of Contact Completing Form:

Phone Number:

Patient Information

PATIENT'S CONSENT IS REQUIRED TO CONDUCT INSURANCE RESEARCH. By providing consent, the patient authorizes us to contact the insurer to conduct research and relay the patient's name, date of birth, social security number, diagnosis, and insurance information.

Do you have the patient's consent on file? ◯ Yes ◯ No

Patient's Name:

Address (no PO boxes please):

Phone Number:

Date of Birth:

Social Security Number:

Diagnosis and Other Pertinent Medical Information

Product Requested: ☐ **INJECTAFER®** (ferric carboxymaltose injection)

Anticipated Date of Service:

Diagnosis:

Primary Diagnosis:

Secondary Diagnosis:

Setting of Care: ◯ Physician's Office ◯ Hospital Outpatient ◯ Other (please specify):

Insurance Information

Primary Insurance (Insurer Name and State):

Participating Provider: ◯ Yes ◯ No

Payer Provider Number:

Phone Number:

Fax Number:

Policy Holder's Name:

Date of Birth:

Social Security Number:

Employer's Name:

Policy Number:

Group/Plan Number:

Secondary Insurance (Insurer Name and State):

Participating Provider: ◯ Yes ◯ No

Payer Provider Number:

Phone Number:

Fax Number:

Policy Holder's Name:

Date of Birth:

Social Security Number:

Employer's Name:

Policy Number:

Group/Plan Number:

☐ *If your Patient has tertiary insurance, please fill out an additional Insurance Verification Request Form.*

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Physician Information

Prescribing Physician Name:

NPI Number:

Tax ID Number:

Provider Specialty:

DEA Number:

Facility/Practice Name:

Address:

Phone Number:

Fax Number:

If prior authorization (PA) is required would you like us to initiate the PA process? ○ Yes ○ No

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