CPT code# 90620

GSK Vaccines Reimbursement Support Center

BEXSERO® (Meningococcal Group B Vaccine) INSURANCE CHECKUP™ SUBMISSION FORM

You must submit a completed, signed form. You must also submit copies of the front and back of patient insurance cards.

Physician Information

Physician Name:		Practice Name:		
Street Address:		City:	State:	ZIP:
Phone:	Fax:	E-mail:	Office Contact:	

Patient Information

First and Last Name:

Phone:	Date of Birth: _____/_____/_____	O Male	O Female
Street Address:	City:	State:	ZIP:

Insurance Information (Attach copy, front and back, of patient insurance cards)

Primary Insurance Name:	Phone:
Subscriber Name:	Relationship to Patient:
Subscriber ID #:	Group ID #:

PATIENT AUTHORIZATION AND RELEASE TO COLLECT, USE, AND DISCLOSE MEDICAL INFORMATION

I understand that the collection, use, and disclosure of my health information are protected under law. Information contained in this Enrollment Form, such as my name, address, insurance, prescription, and medical information, is "protected health information." By signing below, I agree to the collection, use, and disclosure of my protected health information as described below.

I understand that my healthcare providers will not condition my medical treatment on my agreement to sign this Patient Authorization and Release. I understand that once information about me is released based on this authorization, federal privacy laws may not prevent the entities described below from further disclosing my information. However, I understand that such entities have agreed to only use or disclose information it receives for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for 180 days or until my coverage, coding, reimbursement, or other inquiry has been resolved, whichever is longer.

I also understand that I have the right to revoke this authorization at any time by calling 855-636-8291 and mailing a signed written statement of my revocation to the GSK Vaccines Reimbursement Support Center at PO Box 29212, Phoenix AZ 85038-9212, but that such a revocation would end my eligibility to participate in the program as described. Revoking this authorization will prohibit disclosures after the date written revocation is received, except to the extent that action has been taken in reliance on this authorization. This means that, after you revoke this authorization, your information may be disclosed among GlaxoSmithKline ("GSK") and the company or companies that help GSK administer the programs in order to maintain records of your participation, but it will not be otherwise disclosed or used.

Enrollment in the Reimbursement Support Center Program

The patient, or the patient's authorized representative, MUST sign this form in order to receive reimbursement support and assistance from the GSK Reimbursement Support Center (the "RSC"). Before signing, you, the patient, should review, understand, and agree to the terms of this authorization and release.

By signing below, I authorize GSK, as well as McKesson Specialty Services and any other companies that GSK uses to administer the RSC, to do the following:

1) Request and receive from my doctor, healthcare provider, health insurer, or pharmacist information necessary to investigate and resolve my coverage, coding, or reimbursement inquiry;
2) Collect, use, and disclose to each other any information that I provide to the RSC for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer the RSC;
3) Disclose to my treating physician, healthcare professional, or pharmacist information I have provided when necessary to resolve my coverage, coding, or reimbursement inquiry. By signing below, I also authorize my insurer, doctor, healthcare provider, and pharmacist to release information about my prescribed medications, vaccination history, and medical condition requested by GSK and McKesson Specialty Services;
4) Disclose any information obtained from the sources listed above to third parties if required by law.

Patient Name (print): ______________________________ Date: _____/_____/_____

Signature of Patient or Patient Representative: ______________________________

Relationship (if other than patient): ____________________ Patient e-mail: ____________________

UPON COMPLETION, PLEASE FAX THIS FORM TO GSK VACCINES REIMBURSEMENT SUPPORT CENTER AT 877-683-1329 AND PLEASE CALL 855-636-8291 WITH ANY QUESTIONS.

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