Patient Copay Reimbursement Form

In order to receive reimbursement, you must submit this form within **180 days** from date of service

For questions, call 1-844-MyiDose | 844-694-3673 Monday - Friday, 8:00 am - 8:00 pm ET Fax: 1-844-iDoseFx | 844-436-7339

Please complete all sections of this form. All information is required unless marked as optional. Please submit one form per explanation of benefits (EOB). Eligible patients are expected to be issued copay reimbursement in 2-3 upon receipt of completed application.Please complete all the information in print and fax to 1-844-iDoseFx (1-844-426-7339).

Section 1: Patient Information

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____ Gender: ___ F ___ M ___ U

Address (Street, Apt/Suite): _____

City: _____ State/ZIP: _____

Phone: _____ Email: _____

Section 2: Treatment Details

Date of Service: _____ Product Name: _____

Eye Treated: ___ Right ___ Left ___ Bilateral

Out-of-Pocket ($) Classified Drug: _____

Out-of-Pocket ($) Classified Procedure: _____

Section 3: Prescriber Information

First Name: _____ Last Name: _____

Address (Street, Apt/Suite): _____

City: _____ State/ZIP: _____

Phone: _____ Email: _____

NPI Number (Optional): _____

Practice Name: _____ Office Fax Number: _____

Treatment Location Name (if different from Practice Name): _____

Treatment Location Phone: _____

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Section 4: Copay Payment Status

Have you paid the copay out-of-pocket? ___ Yes ___ No

If Yes, and you are seeking reimbursement directly, proof of payment is required along with the Explanation of Benefits (EOB).

If No, the reimbursement will be issued directly to the provider.

Patient Certification

I certify that my prescription medication for which I am seeking copay assistance is not paid for, in whole or in part, by any state or federal government program. The information I am providing is accurate to the best of my knowledge, and the medication copay expenses for which I am seeking assistance were actually incurred. I agree to the Terms and Conditions of the program.

Patient Signature: _____

Date: _____

Submission Instructions

Please submit this completed form along with:

- A copy of your proof of payment (e.g., receipt, credit card statement, or canceled check). (Required if seeking patient reimbursement directly)
- A copy of your Explanation of Benefits (EOB) from your insurance provider.

Submit via:

Fax: 1-844-iDoseFx | 844-436-7339

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