Provider Copay Claim 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). Please complete all the information in print and fax to 1-844-iDoseFx (844-436-7339).

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 (Optional): _____

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: _____

Practice NPI: _____ Practice Tax ID: _____

Site of Care Name (if different from practice information): _____

Site of Care NPI: _____ Site of Care Phone: _____

iDose® TR
(travoprost intracameral implant) 75 mcg

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Section 4: Remittance Address (if information is different from practice)

Remit To Name: _____ Remit To State: _____

Remit To Street Address: _____ Remit To Zip Code: _____

Remit To City: _____ Remit To Phone Number: _____

Healthcare Provider Certification and Signature

iDose TR Copay Assistance Program Terms and Conditions

The iDose TR Copay Assistance Program ("Program") is valid ONLY for patients with commercial (private or non-governmental) insurance who have a valid prescription for a Food and Drug Administration (FDA)-approved indication for iDose TR. Patients using Medicare, Medicaid, Medigap, Veterans Affairs (VA), Department of Defense (DoD), TRICARE or any other federal or state government program (collectively, "Government Programs") to pay for iDose TR and/or administration services are not eligible. The Program is not valid if the costs are eligible to be reimbursed in their entirety by commercial insurance plans or other programs.

Under the Program, the patient may be required to pay a copay. The final amount owed by a patient may be as little as $0 for iDose TR, one implant per eye. The total patient out-of-pocket cost is dependent on the patient's health insurance plan. The Program assists with the cost of iDose TR. It does not assist with the cost of other administrations, medicines, procedures, or office visit fees. The Program benefit amounts cannot exceed the patient's out-of-pocket expenses for iDose TR. The Program is not health insurance or a benefit plan. The patient's non-governmental insurance is the primary payer.

Once a patient is enrolled, the Program will honor claims with a date of service that precedes Program enrollment by 180 days. Claims must be submitted within 180 days from the date of service unless otherwise indicated. Use of this Program must be consistent with all relevant health insurance requirements. Participating patients, pharmacies, physicians' offices and hospitals are responsible for reporting the receipt of all the Programs' benefits as required by any insurer or by law. Program benefits may not be sold, purchased, traded or offered for sale.

The patient or their guardian must be 18 years of age or older to receive assistance from the Program. The Program is only valid in the United States and U.S. Territories and are void where prohibited by law.

The value of the Program is intended exclusively for the benefit of the patient. The funds made available through the Program may only be used to reduce the out-of-pocket costs for the patient enrolled in the Program.

Glaukos reserves the right at any time to delete, modify, or change the terms and conditions without notice.

Provider Signature: _____

Date: _____

Submission Instructions

Please submit this completed form along with:

A copy of the Explanation of Benefits (EOB) from the patient's insurance provider.

Submit via: Fax: 1-844-iDoseFx 844-436-7339

GLAUKOS
TRANSFORMING VISION