

**INVIVYD PATIENT SAVINGS PROGRAM REIMBURSEMENT FORM**

This form must accompany a claim submitted for reimbursement for the Invivyd Patient Savings Program.

**INSTRUCTIONS:**

- If you paid your bill and want the remittance check sent directly to you, check this box and complete **Section A** and **Certification Statement** only.
- If you did not pay your bill and need the remittance payment sent directly to your provider’s office, check this box and complete **Section A, Section B and Certification Statement**.

**Section A: Patient Information (all fields are required)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Savings Card ID: \_\_\_\_\_ Group: \_\_\_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Section B: Provider Information (all fields are required)**

Practice Name: \_\_\_\_\_ Practice NPI: \_\_\_\_\_

Administering HCP Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**ADDITIONAL INSTRUCTIONS FOR CLAIM SUBMISSION:**

**What to submit with your claim**

1. Complete this form following the instructions next to the checkbox selected and sign Certification Statement.
2. If the 1<sup>st</sup> checkbox was selected (reimbursement sent to you), include a copy of your EOB and proof of payment.
3. If the 2<sup>nd</sup> checkbox was selected (reimbursement sent to Provider), include a copy of your EOB only.

*Note: Additional documentation, such as a CMS 1500/UB04 form, may be requested from the Provider if necessary.*

**Where to submit your claim**

1. Fax this form to (908-548-9472) or Mail to [430 Mountain Avenue, Suite 105, New Providence, NJ 07974], ATTN: Claim Processing Department  
-OR-
2. Use portal account to submit online at Invivyd Patient Savings Portal [Invivyd.patientsavings.com]

**CERTIFICATION STATEMENT:**

Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

- By signing the above, you attest that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by your insurance or any other payer.