Daiichi-Sankyo | access central 4U™

Patient Savings Program Check Request Form

INSTRUCTIONS

1. Complete all required fields
2. Print the form
3. Obtain patient signature
4. Fax the following to 1-833-471-9988:
   - ☐ Completed form
   - ☐ Explanation of Benefits (EOB)
   - ☐ CMS1500 Form
   - ☐ Itemized physician receipt

The EOB provided must include the name of the insurance company, date of service, product name/J-code, and patient responsibility amount.

Daiichi Sankyo AccessCentral4U | 1-866-4-DSI-NOW (1-866-437-4669) | DSAccessCentral4U.com

Please check 1 box:

☐ Patient (check will be made payable to patient and mailed to address indicated below)

☐ Practice/Physician (check will be made payable to practice and mailed to address indicated below)

PATIENT INFORMATION

Patient Name: _____

Patient Address: _____

Patient Phone: _____ Date of Service: ___/___/___ MM/DD/YYYY

Card ID: _____ Amount Requested: $ _____

Physician Name: _____

Physician Phone: _____

This section should only be completed if the check is being mailed to a physician or practice.

Physician or Practice Name: _____

Address: _____

PATIENT SIGNATURE (OR AUTHORIZED REPRESENTATIVE): _____ Date: ___/___/___ MM/DD/YYYY

Patient Savings Program Check Request Form *(cont'd)*

TERMS AND CONDITIONS: For product-specific Patient Savings Program terms and conditions, please visit DSAccessCentral4U.com, select a product, and navigate to Patient Savings Program information.

CONFIDENTIALITY NOTICE: This form transmission is intended only for the addressee shown above. It may contain information that is privileged, confidential, or otherwise protected from disclosure. Any review, dissemination, or use of this transmission, or any of its contents by persons other than the addressee, is strictly prohibited. If you received this fax in error, please call us immediately upon receipt for instructions. Thank you for your cooperation.

HMO, health maintenance organization.

Daiichi-Sankyo | access central 4U™

PP-US-NP-2601 01/25