GSK Vaccines Reimbursement Support Center

GSK

INSURANCE CHECKUP™ SUBMISSION FORM

Product Information

Vaccine Name:		
NDC (if available):	ICD-10 Code:	CPT Code:

Physician Information

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

Patient Information

First and Last Name:			
Phone:	Date of Birth:	☐ Male ☐ Female	
Street Address:	City:	State:	ZIP:

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

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

Application Checklist

- ❑ **Page 1 of Enrollment form Completed**
- ❑ **Complete & sign (signature of either patient or HCP/ Covered Entity Authorized Representative is required)**
  - ❍ **Section 1 (Patient Signature)**

    OR
  - ❍ **Section 2 (signature of HCP/Covered Entity Authorized Representative)**
- ❑ **Fax both pages of the form to GSK Vaccines Reimbursement Support Center upon completion to 877-683-1329 and please call 855-636-8291 with any questions.**

GSK

Complete Section 1 (patient signature)

OR

Section 2 (if applicable - HCP/Covered Entity Authorized Representative signature).

IT IS NOT NECESSARY TO COMPLETE BOTH SECTIONS

The patient, or the patient's authorized representative, OR the HCP or other representative of the covered entity authorized to make certification, MUST sign this form in order to receive reimbursement support and assistance from the GSK Vaccines Reimbursement Support Center (the "VRSC")

SECTION 1 (patient signature)

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 they receive for the purposes described in this authorization or as required by law. I understand that this authorization will remain in effect for one (1) year 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 610 Crescent Executive Court, Suite 200, Lake Mary, FL 32746, 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 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.

By signing below, I authorize GSK, as well as Caremetx and any other companies that GSK uses to administer the VRSC, 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 VRSC for the purpose of investigating and resolving my coverage, coding, or reimbursement inquiry or to administer the VRSC;
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 Caremetx;
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: _____

SECTION 2 (signature of HCP or other individual authorized by covered entity to make certification)

CERTIFICATION OF HIPAA CONSENT

I certify that I have the authorization/consent necessary under HIPAA to share all information needed for this application with pharmaceutical manufacturer (GSK), and its agents and representatives (e.g., Caremetx) for purposes of investigating and resolving coverage, coding or reimbursement inquiry.

_____ Date: _____

Name of HCP or other individual authorized by covered entity (print):

_____

Signature of HCP/Individual Authorized by Covered Entity:

©2024 GSK group of companies or its licensor.
Printed in USA. February 2024