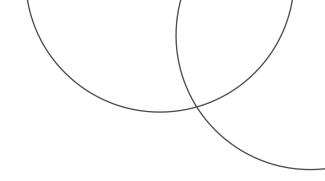
Understanding Your Patient's Benefit Verification Form



After *EntyvioConnect* verifies a patient's insurance coverage for either IV administration and maintenance or SC pen maintenance, your office will receive a summary of the findings. The first sample form is blank, with explanations next to each section. The second sample shows what it might look like completed when it comes back to you for review.

Entyvio CONNECT



Phone: 1-855-ENTYVIO (368-9846) Fax: 1-877-488-6814

Insurance Benefit Investigation Results for Patients

Disclaimer: EntyvioConnect is an information service only. The information contained below has been provided by the insurer or third-party payer. This is not a guarantee of coverage or reimbursement now or in the future, and the EntyvioConnect disclaims liability for payment of any claims, benefits, or costs. Confidentiality Notice: This message may contain CONFIDENTIAL information concerning the named addressee. If you are not the named addressee or his/her authorized representative, your DISCLOSURE or USE of this information is PROHIBITED. If you receive this message in error, please notify us promptly and then destroy his document.

A PATIENT INFORMATION

TATIENT IN CHIMATON		
Patient Name: [Firstname Lastname]	Patient DOB: [MM/DD/YYYY] SR ID#: [SR#]	
Insurance: [Payer Name]	Plan Type: [plan type]	
Policy ID: [Payer Policy#]	Plan Renewal Date: [Renewal Date]	

PHYSICIAN INFORMATION

Physician: Dr. [Provider Name]	Phone: [HCP Phone]	Fax: [HCP Fax]
Facility: [Facility Name]	Network Stat	tus: [In-network/Out-of-network]

BENEFIT INVESTIGATION RESULTS

7	Access Options	Entyvio IV Infusion Benefits
	Covered as:	[Major Medical/Prescription]
	Is Entyvio IV Covered?	[Covered/Prior Authorization Required/Not Covered]
> 11	Is the Administration Covered?	[Covered/Not Covered]
	Coinsurance/Co-pay	[Coinsurance/copay]
[Deductible	[\$xx.xx - \$xx.xx met]
	Out-of-Pocket Maximum	[\$xx.xx - \$xx.xx met]
	Annual Maximum	[\$xx.xx - \$xx.xx met]

PRIOR AUTHORIZATION NEXT STEPS (IF APPLICABLE)

[patient PA FUNs]

ADDITIONAL INFORMATION
[patient FUNs]

Access Options	Entyvio IV Infusion Benefits	Entyvio SubC Injection Benefits
Covered as:	[Major Medical/Prescription]	Prescription
Is Entyvio SubC Covered?	[Covered/Prior Authorization Required/Not Covered]	[Covered/Prior Authorization Required/No Covered]
Is the Administration Covered?	[Covered/Not Covered]	N/A (Self-injectable)
Coinsurance/Co-pay	[Coinsurance/copay]	[Coinsurance/copay]
Deductible	[\$xx.xx - \$xx.xx met]	[\$xx.xx - \$xx.xx met]
Out-of-Pocket Maximum	[\$xx.xx - \$xx.xx met]	[\$xx.xx - \$xx.xx met]
Annual Maximum	[\$xx.xx - \$xx.xx met]	[\$xx.xx - \$xx.xx met]



Patient Information

Pertinent patient information and health insurance details.



Physician Information

Contact details and network status.



Benefit Investigation Results

This section includes information on:

- Coverage: Includes how the drug is administered and whether a PA is needed
- Out-of-Pocket costs: Includes Co-pay/ Coinsurance, Deductible, Out-of-Pocket Maximum, and Annual Maximum



Prior Authorization Next Steps

Additional information related to submitting a PA, if applicable.



Additional Information

Summarizes key points from all of the sections contained in this document. Typical information might include how to find a PA form, how to check the policy for additional information, whether a certain specialty pharmacy should be used for the Entyvio Pen, whether the patient is registered in the Co-Pay Program, and the associated Co-Pay Program member ID.

ID=identification; IV=intravenous; PA=prior authorization; SC=subcutaneous.





Example of Completed Benefit Verification Form





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Insurance Benefit Investigation Results for Patients

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PATIENT INFORMATION

Patient Name: John Doe	Patient DOB: 01-01-1980	SR ID#: 00001
Insurance: Health Plan ABC		Plan Type: Commercial
Policy ID: HP00123		Plan Renewal Date: 01-01-2024

PHYSICIAN INFORMATION

Physician: Dr. Jack Jones	Phone: (888) 123-4567	Fax: (888) 123-4568
Facility: Main Street GI Clinic		Network Status:
I acinty. Main Street of Chilic		In-network

BENEFIT INVESTIGATION RESULTS

Access Options	Entyvio IV Infusion Benefits	Entyvio SubC Injection Benefits
Covered as:	Major Medical	Prescription
Is Entyvio SubC Covered?	Covered	Covered
Is the Administration Covered?	Covered	N/A (Self-injectable)
Coinsurance/Co-pay	Coinsurance	
Deductible	\$2,000; \$1,500 met	
Out-of-Pocket Maximum	\$2,000; \$1,500 met	
Annual Maximum	\$2,000; \$1,500 met	

PRIOR AUTHORIZATION NEXT STEPS (IF APPLICABLE)

N/A

ADDITIONAL INFORMATION

Health plan requires a PA that can be retrieved at www.healthplanABC/PA. Patient is eligible for co-pay support and has been enrolled. Member ID is 12345678910

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