MEDICAL CLAIM FORM

EntyvioCONNECT | Entyvio vedolizumab

Must submit with **Primary Insurance EOB** (Explanation of Benefits) via fax to 844-595-6272

Date of Service		**Co-pay Member ID**			
Section 1: Patient Information (* required information)					
First Name*		Last Name*		Middle Name	
Address 1*					
Address 2					
City*		State*		ZIP*	
Gender*	☐ M ☐ F ■ U	DOB*		Phone Number*	
Best time to contact	☐ Morning	☐ Afternoon	☐ Evening		
Relationship to insured*	☐ Self	☐ Spouse	☐ Other Dependent		
Section 2: Insured Information (* required information only if different than Patient)					
First Name*		Last Name*		Middle Name	
Address 1*					
Address 2					
City*		State*		ZIP*	
Gender*	☐ M ☐ F ☐ U	DOB*		Phone Number*	
Section 3: Billing Practice Information (* required information. This section must be filled out completely to ensure proper check delivery)					
Practice Name*		Tax ID*		NPI*	
Address 1*					
Address 2					
City*		State*		ZIP*	
Phone*		Email*		Fax*	
Section 4: Treating Physician/Provider Information (* required information)					
First Name*		Last Name*		Middle Name	
Specialty		Title		NPI*	
Section 5: Payee (select one)					
☐ Patient (Check will be made payable and mailed to the address in Section 1)					
☐ Billing Practice (Check will be made payable and mailed to the address in Section 3)					

Please click to read the full Prescribing Information, including Medication Guide.