MEDICAL CLAIM FORM

EntyvioCONNECT | Entyvio vedolizumab

Must submit with **Primary Insurance EOB** (Explanation of Benefits) via fax to 1-844-595-6272

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 for full Prescribing Information, including Medication Guide, for ENTYVIO and talk with your healthcare provider.

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