

MEDICAL CLAIM FORM

EntyvioCONNECT



Submit with **Primary Insurance EOB** via fax to 844-595-6272

Date of Service:		Co-pay MemberID:		Co-Pay Group Number:	
Section 1: Patient Information (* required information)					
First Name*		Last Name*		Middle Name	
Address 1*					
Address 2					
City*		State*		Zip*	
Gender*	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	DOB*		Phone Number*	
Best time to contact	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	Email			
Relationship to insured*		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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*	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	DOB*		Phone Number*	
Section 3: Billing Practice Information (* required information)					
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 (To Be Mailed to the Address Above)					
<input type="checkbox"/> Patient <input type="checkbox"/> Billing Practice					

Please click [here](#) to read the full **Prescribing Information**, including **Medication Guide**.

Q CODE / BAR CODE

ENTYVIO is a trademark of Millennium Pharmaceuticals Inc., registered with the U.S. Patent and Trademark Office, and is used under license by Takeda Pharmaceuticals America, Inc.