VYEPTI Copay Assistance Program
PO Box 2355
Morristown, NJ 07962
Phone: 833-4-VYEPTI
Fax: 866-218-3479

VYEPTI Copay Assistance Program – Reimbursement Request Form

Patient First Name:____

Patient Last Name:____

Patient Date of Birth:____

Parent or Guardian Name:____________________________________
(if applicable)

Provider Name: ____

VYEPTI Copay Assistance Program Member ID: ________________________
(located on your Welcome Letter or call 833-4-VYEPTI)

Reimbursement Payable to ☐ Patient ☐ Parent or Guardian

Payee Name:____

Address:____

Address Line 2: ____

City/State/ZIP: ____

Phone Number: ____

Amount Requested:____

Signature

Patient Signature:____

Parent or Guardian Signature:__________________________________
(if applicable)

Print Name:____

Date:____

Please send the completed form, along with the patient's detailed Explanation of Benefits (EOB), to the fax number above or mail to the address above.

A detailed EOB includes insurance carrier name and logo, name of the plan, patient's financial responsibility, date of service, and treatment provided—by drug name, J-code, or National Drug Code (NDC). For reimbursement to the patient, a copy of the paid receipt must also accompany the above.

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