

Please complete this form and submit with all required information and attachments to be considered for reimbursement.

Do not submit claims for any prescription covered under Medicare, Medicaid, CHAMPUS, TRICARE or any state- or federally-funded programs, nor for any amount covered by insurance, FSA or HSA as they are not eligible for payment.

Patient Information

First Name	Last Name	Date of Birth (MM/DD/YYYY)
Address		Apt./Suite No.
City	State	ZIP
Email	Phone	Fax

Your email address will be used ONLY for claim status notification. It will be kept confidential and NOT provided to any other party.

RxGrp#	RxID#
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Please refer to your card or printed offer for this required information.

☐ Check this box if you are including a copy of your copay card or printed offer with this claim request to ensure accuracy.

Insurance Information

Do you have Health Insurance? ☐ No ☐ Yes and my insurer for prescription benefits is: _____

My insurance covered: ☐ This entire prescription ☐ None of this prescription ☐ All except copay of \$ _____

This prescription was filled at: ☐ A retail pharmacy store ☐ Through mail order or specialty pharmacy (EOB required)*

**Specialty/Mail order claims require a copy of the Explanation of Benefits for this prescription from your insurance provider.*

Pharmacy Receipt

Mail this completed form **along with the items listed below** to the following address:

AbbVie Claims Processing Dept., PO Box 2355, Morristown, NJ 07962.

Or, you may fax this completed form **along with the items listed below** to **908-809-6229**.

Failure to include any of the following will result in claim rejection:

1. The original pharmacy receipt received from your pharmacy with your Rx (see sample receipt, right) which must include the following information:
 - Patient name and address
 - Pharmacy name, address and phone
 - Doctor or health care provider name, address and phone number
 - Prescription # (RX #), fill date, drug name, strength, NDC #, and quantity
 - Overall prescription price and copay amount/out of pocket expense paid
2. Copy of your EOB (if required in Insurance Information section above)
3. The cash register receipt with the amount paid for this prescription clearly identified
4. Copy of your primary insurance card (including both front and back of the card)



Certification Statement

"I, _____, certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred and that they were not and will not be paid by my insurance, my Flexible Spending Account (FSA), Health Savings Account (HSA) or any other payer. I certify that I am not covered under Medicare, Medicaid, TRICARE, CHAMPUS or any other government (state- or federally-funded) program and I understand that I am liable for any misrepresentations herein to the full extent of applicable law."

Claimant/Patient/Legal Guardian Signature _____ Date _____

Please allow 2–4 weeks for processing. This form can be used for multiple submissions.