OpusHealth™ **CompleteRebate.com** **Tel: 1.800.364.4767**

Complete this form and submit with the required receipts to be considered for rebate.

Patient Information

Name (Last, First): _____, _____

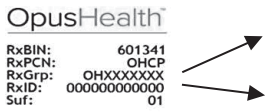
Address (Street): _____ **Date of Birth:** ☐☐/☐☐/☐☐☐☐

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.)

Please refer to the OPUS Health box, found on your card or printed offer, for the required information. It will look similar to the example shown (right).



OH☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

[ ] Check this box if you are including a copy of your co-pay card or printed offer with this claim request to ensure accuracy.

Pharmacy Documents

Please be sure to include all of the following to avoid claim rejection or delay:

1. The original pharmacy label received from your pharmacy with your Rx (see sample label, 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 co-pay amount/out-of-pocket expense paid
2. A receipt (register, pharmacy, explanation of benefits, or other) that clearly identifies the amount paid for this prescription

LABEL
OPUS-ISM PHARMACY
1324-106 MOTOR PARKWAY
HAUPPAUGE, NY 11749

RX: 100053 Filled:03/31/05
SMITH, JOHN Q **(CC)**
123 MOTORPARK WAY
HAUPPAUGE, NY 11788 **OFI**
MYDRUG 120 MG
Qty:30 **NDC:00000000000**
No Refills
NO AUTHORIZATION REQUIRED

DR. JONES, TOM
1324 MOTOR PARKWAY, HAUPPAUGE, NY11788
AA0000000 (631)582-6787

RxPrice: $xxx.xx

THIS IS YOUR LABEL. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Certification Statements

I, _____, certify that I agree with and acknowledge each of the statements below, and indicate so by checking these boxes. [Note: You must agree to and acknowledge each statement for your claim to be eligible.]

- ☐ The information I have submitted on this form and accompanying this form is complete, correct, and valid.
- ☐ I understand that any rebate will be applied after an initial minimum payment of $5.
- ☐ I am self-insured or have commercial insurance.
- ☐ Participation in this program is not prohibited by my insurance provider.
- ☐ I am not a participant of Medicare Part D, VA, TRICARE, Medicaid, or any similar federal or state program.
- ☐ Prescription was not paid using funds from an FSA, HSA, or HRA.
- ☐ I understand and accept the terms and conditions below.

Claimant/Patient/Legal Guardian Signature: _____ Date: _____

Claim Submission

Submit completed form and receipts via mail or fax to:

MAILING ADDRESS: **IQVIA, Inc.**
77 Corporate Dr.
Bridgewater, NJ 08807
Attn: Claims Processing Dept

-OR-

FAX NUMBER: 1.631.822.2893

Eligibility

Terms and Conditions apply. Eligibility: Available to patients with commercial prescription insurance coverage who meet eligibility criteria. Co-pay assistance program is not available to patients receiving prescription reimbursement under any federal, state or government-funded insurance programs (for example, Medicare (including Part D), Medicare Advantage, Medigap, Medicaid, TRICARE, Department of Defense or Veteran's Affairs programs) or where prohibited by law or by the patient's health insurance provider. If at any time a patient begins receiving prescription drug coverage under any such federal, state or government-funded healthcare program, patient will no longer be able to use the co-pay assistance program and patient must call 1-800-364-4767 to stop participation. Patients residing in or receiving treatment in certain states may not be eligible. Patients may not seek reimbursement for value received from the co-pay assistance program from any third-party payers. Offer subject to change or discontinuance without notice. Restrictions, including monthly maximums, may apply. This is not health insurance.

Please allow up to 5 business days after receipt of correct information to receive rebate.
For assistance completing this form, contact OPUS Health at 1.800.364.4767 and select the *Patients* option.

©2020 AbbVie Inc. North Chicago, IL 60064 US-MULT-200156 May 2020 Printed in U.S.A.