IQVIA, Inc. / 430 Mountain Ave. Ste. 105 / New Providence, NJ 07974 / Attn: Claims Processing Dept. PTR.patientsavings.com Tel: 1-888-636-1337

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 - none of which are eligible for reimbursement.

Patient Information

Name (Last, First): _____ , _____ **Date of Birth:** ____ / ____ / ____

Address (Street): _____ Apt./Suite No. _____

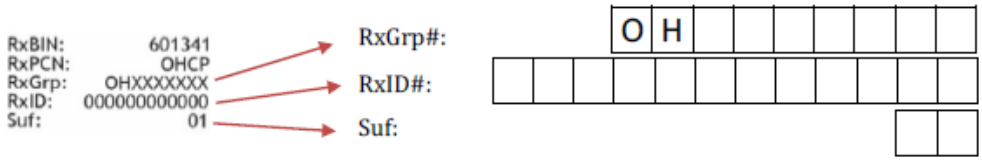
City: _____ **State:** _____ **Zip:** _____ - _____

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

Phone: ( ) _____ - _____ **Fax:** ( ) _____ - _____

Savings Card Information

Please refer to the copay information, found on your savings card, for the required information. Example below.



Name of drug you are submitting a claim for: _____

[ ] Check this box if you are including a copy of your savings card to ensure accuracy

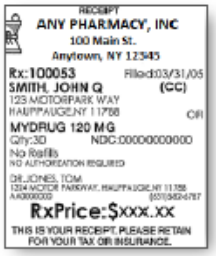
Insurance Information

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

Pharmacy Receipt

Mail this completed form along with the following items to: **Attn: Claims Processing Department, IQVIA, Inc., 430 Mountain Ave. Ste. 105, New Providence, New Jersey 07974** or submit your claim online at PTR.patientsavings.com
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 label at the right)* which must include the following information:
   - Patient name and address
   - Pharmacy name, address, and phone number
   - 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. The **cash register receipt or Explanation of Benefit (EOB)** with the amount paid for this prescription clearly identified.
3. A **copy of your primary insurance card**, including both front and back of the card


RECEIPT
ANY PHARMACY, INC
100 Main St.
Anytown, NY 12345
Rx:100053 Filled:03/31/05
SMITH, JOHN Q (CC)
123 MOTORPARK WAY
HAUPPAUGE,NY 11788 OR
MYDRUG 120 MG
Qty:30 NDC:00000000000
No Refills
NO AUTHORIZATION REQUIRED
DR.JONES, TOM
RxPrice:$xxx.xx
THIS IS YOUR RECEIPT. PLEASE RETAIN FOR YOUR TAX OR INSURANCE.

Certification Statement

By signing below, I certify: (1) The information I am submitting in support of my claim for reimbursement is true and accurate; (2) The expenses for which I am requesting reimbursement were actually incurred and are not eligible for payment/reimbursement from my medical or prescription insurance; (4) **I am not enrolled in any state, federal, or government funded healthcare program, including, without limitation, Medicaid, Medicare, Medicare Part D, Medicare Advantage, Medigap, DoD, VA, TRICARE®/CHAMPUS, or any state prescription drug assistance program**; and (4) I did not pay for these expenses with a flexible savings account (FSA), health savings account (HSA), or health reimbursement account (HRA).

In support of my claim for reimbursement of my pharmacy expenses, I authorize Lilly USA, LLC and its agents to contact my pharmacy or other healthcare providers to disclose and obtain information about the pharmacy claim for which I am seeking reimbursement.
A copy of this authorization is as valid as the original, and this authorization will be valid even if I sign it electronically.

Claimant/Patient/Legal Guardian Signature: _____ Date_____

Please allow 4-6 days for processing. This form can be used for multiple submissions.
For assistance completing this form, contact IQVIA at 1-888-636-1337 and select the "Patient" option.

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