We Pay the Difference patient reimbursement program submission form

OMIDRIAssure®
SUPPORT AT EVERY STEP

The Explanation of Benefits (EOB) and CMS billed claim forms for the patient(s) listed below have been provided to the OMIDRIAssure® program for review. So that the OMIDRIAssure program can provide reimbursement support services for the listed patient(s) and, if needed, process payment for the We Pay the Difference patient reimbursement program for commercially insured patients, the Office Certification at the bottom of this form must be signed by either the physician or the administrator and faxed to the OMIDRIAssure program at 1-855-664-3741. We Pay the Difference Commercial Reimbursement requests will be accepted up to and including 180 days from date of service. Requests received beyond 180 days will be denied.

Patient Information

First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

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First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

First Name: ____________ *Last Name:* ____________ *DOB:* ________ *Date of Surgery:* ________ *Physician Name:* ________________ *Member ID #:* ________

Facility Name: ______________________ Facility Address: ______________________

Facility Phone Number: ______________________ Facility Email Address: ______________________

Office Certification

My signature below certifies that the patient(s) named above is/are my patient(s) or patient(s) of this surgery center and that the information provided is, to the best of my knowledge, complete and accurate. I have obtained each patient's authorization, or have confirmed that each patient's authorization had been obtained, to disclose his/her personal and health information to the OMIDRIAssure program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. I consent to Rayner's representatives and agents contacting me and this surgery center to confirm receipt of OMIDRIA or to provide additional information about OMIDRIA and the OMIDRIAssure program. Once payment is received from the OMIDRIAssure program, I and this surgery center agree promptly to return any copay/coinsurance collected from the patient(s) named above for OMIDRIA. I and this surgery center agree that Rayner may change or terminate any of the OMIDRIAssure program services at any time without notice.

Signature: ______________________________ Date: ____________

Signatory Name / Title: ______________________________

Please fax completed and signed form to 1-855-664-3741

OMIDRIAssure program services are subject to change without notice. The We Pay The Difference Commercially Insured Patient Reimbursement Program patient benefit is not available for patients with any government insurance. Rayner does not guarantee reimbursement. Facility acquisition cost is determined after application of any volume-based discount. Claims must be submitted within 180 days of the date of surgery.

OMIDRIA®
(phenylephrine and ketorolac intraocular solution)
1% / 0.3%

Rayner