

We Pay the Difference patient reimbursement program submission form

The Explanation of Benefits (EOB) forms for the patient(s) listed below have been provided to the OMIDRIAAssure[®] program for review. So that the OMIDRIAAssure 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 OMIDRIAAssure program at 1-855-664-3741.

Patient Information

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

First Name: _____ Last Name: _____ DOB: _____ Date of Surgery: _____ Physician Name: _____

Facility Name: _____ Facility 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 OMIDRIAAssure program to use and to disclose as necessary in connection with the possible provision of patient and/or reimbursement support services. I consent to Omeros Corporation's representatives and agents contacting me and this surgery center to confirm receipt of OMIDRIA or to provide additional information about OMIDRIA and the OMIDRIAAssure program. Once payment is received from the OMIDRIAAssure 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 Omeros Corporation may change or terminate any of the OMIDRIAAssure program services at any time without notice.

Signature: _____ Date: _____

Signatory Name / Title: _____

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

OMIDRIAAssure 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. Omeros does not guarantee reimbursement. Facility acquisition cost is determined after application of any volume-based discount. Claims must be submitted within one year of date of surgery.

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