Nucala Co-pay Program Reimbursement Form

Please complete form and submit to be reimbursed

1 PATIENT ENROLLMENT CONFIRMATION

*Patient First Name *Patient Last Name

Member ID (Found on member's card) Date of Birth

Patient Mailing Address Apartment/Unit/Suite

City State Zip

2 PHYSICIAN AND PRACTICE CONFIRMATION

*Physician First Name *Physician Last Name

*Practice Name and Location

Practice Mailing Address Apartment/Unit/Suite

City State Zip

3 PAYMENT INFORMATION

***Certification and Authorization:**
I certify that the information on this form is accurate and complete. I am requesting reimbursement for eligible out-of-pocket costs for the NUCALA medication I have already received. I have not and will not seek reimbursement of this expense from any other plan or party.

*Payment Recipient (Please check one) ☐ Patient(check) ☐ Practice (Virtual Debit Card or ACH only)

Please include copy of Explanation of Benefits (EOB)

*Date of Service *Amount Requested

*In addition to the documentation required by the program, when selecting "Patient" as a check recipient, make sure to include **proof of payment** as part of the document submission.*

*Patient Signature *Date

*Preferred Fax-Back Number for Notification (Optional)

Entering a fax number here indicates you would like to receive fax confirmation that the check has been sent to the address provided.

Please send the completed form along with Explanation of Benefits (and Proof of Payment, if required) to:

- **FAX**: 866-728-8222

OR

- **MAIL TO**: GSK Co-pay Program
  PO BOX 1326
  Morristown, NJ 07962

Requests must meet all program criteria in order to be considered for reimbursement.
The NUCALA Co-pay Program does not provide reimbursement for administration fees in Massachusetts, Minnesota and Rhode Island.