CareASSIST™
Oncology and Transplant
Patient Support by Sanofi Genzyme

PO Box 220616
Charlotte, NC 28222
Phone: **1-833-WE+CARE** (1-833-930-2273)
Fax: 1-855-411-9689
SanofiCareAssist.com

Patient Guide to Filing a Request for Reimbursement

Some pharmacies and providers may not participate in the CareASSIST Copay Program. In these instances, we encourage you to use the attached Proof of Expense Form to be reimbursed for these expenses.

Proof of Expense Form

The CareASSIST Copay Program provides you copay assistance for product-specific charges. The program does not cover or provide reimbursement for supplies, services, physician office visits or other medical procedures.

Please ensure that the following information is provided on the Proof of Expense form:

1. In order to obtain financial assistance from the CareASSIST Copay Program, the attached Proof of Expense Form must be completed and supporting documentation provided for each expense billed.

2. This supporting documentation must include: insurance Explanation of Benefits, payment receipts, billing statements, and/or other expense documentation. Payment cannot be issued without proof of expense.

3. For each expense, please provide the following:
   - Amount of payment being requested for this product
   - To whom the check should be made
   - Address where the check should be mailed
   - Telephone number of provider if available

4. Please complete a separate claim for each family member.

5. The Proof of Expense form must be signed and dated by the person filling out the form. Once complete, please fax or mail the form and all required items to:

   CareASSIST Copay Program
   PO Box 220616
   Charlotte, NC 28222

   Fax: 1-855-411-9689

6. The form will be reviewed and processed upon receipt. Forms must be submitted within 120 days of the date of service for which you are seeking reimbursement.

7. Payment will be dispersed within 7-14 business days of the receipt of a complete request.

   If you have any questions about the Proof of Expense Form or the payment process, please call the CareASSIST Copay Program at 1-833-WE+CARE (1-833-930-2273).

For any questions or concerns, or to report side effects with a Sanofi Genzyme product for patients enrolled in the CareASSIST Patient Support Program, please contact CareASSIST at 1-833-930-2273, Monday-Friday, 9 AM-8 PM Eastern Time.

Sanofi Genzyme is committed to protecting the confidentiality of individuals' personal healthcare information. This letter may contain personal healthcare information and should only be viewed by the individual to whom it is addressed. Please contact CareASSIST at 1-833-930-2273 if you believe you have received this letter in error.

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Proof of Expense Form

[Patient_First_Name] [Patient_Last_Name]
CareASSIST Patient ID [Record_ID]

Supporting documentation must be provided for each expense billed. This includes: Explanation of Benefits, payment receipts, billing statements, and/or other expense documentation.

Section 1 – Expenses

Expense:		
Date Product Received (MM/DD/YYYY):		
Amount of Reimbursement Requested:		
Make Check Payable to:		
Address:		
City:	State:	Zip:
Telephone Number for Provider (if available):		

Section 2 – Declaration

I verify that the information provided on this form is complete and accurate. I further understand that reported information may be verified by an audit as deemed necessary by the CareASSIST Copay Program (the "Program"). I understand that assistance will end if the Program becomes aware of any fraudulent activity relating to the assistance provided by the Program. I understand that assistance may be limited to the terms and conditions established by the Program and that the Program reserves the right at any time or for any reason, and without notice to (i) modify this form, (ii) modify or discontinue the Program and the related eligibility criteria, or (iii) terminate assistance.

I authorize the Program and its employees, third party administrators, agents and other representatives to obtain treatment and insurance-related information from my health care providers and insurance coverage information from my employer or insurance company(ies) as necessary to complete the reimbursement process or to verify the accuracy of any information provided with this form.

Patient/Guardian Signature **Date**

Relation to Patient _____

Please return this completed form to:

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PO Box 220616
Charlotte, NC 28222

Fax: 1.855.411.9689

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