Skyla®
(levonorgestrel-releasing intrauterine system) 13.5 mg

Mirena®
(levonorgestrel-releasing intrauterine system) 52 mg

Bayer Women's HealthCare Support Benefit Investigation Request Form

Reimbursement Support Program Phone: (866) 647-3646, option 1 for Mirena® or option 2 for Skyla®; then option 1 for HCP; then option 2 for BI; Fax: (877) 946-1000

Physician Information

Licensed Physician Name: _____
Tax ID #: _____ DEA: _____
State License #: _____
State of License: _____
NPI #: _____
Medicaid ID #: _____
Payer-Specific Provider #: _____

Practice Information

Site Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
Office Contact: _____
Best Time to Call: _____

Product Selection/Diagnosis Code

Check all that apply

❒ **Skyla**
❒ V25.11 (Z30.430) ❒ Other: _____

❒ **Mirena**
❒ V25.11 (Z30.430) ❒ 626.2 (N92.0) ❒ 627.0 (N92.4)

Other: _____ Insertion Date: _____

Patient Information

Name: _____
Date of Birth: _____
Address: _____
City: _____
State: _____ ZIP: _____
Phone: _____

Patient Insurance

Primary Insurance Name: _____
Policy #: _____ Group: _____
Insurer Phone: _____
Employer: _____
Policy Holder Information (if different from patient)
Name: _____
Relation to Patient: _____

Secondary Insurance Name: _____
Policy #: _____ Group: _____
Insurer Phone: _____
Employer: _____
Policy Holder Information (if different from patient)
Name: _____
Relation to Patient: _____

Authorizations

Healthcare Provider (please check the appropriate box)

❒ I certify that Skyla therapy is medically necessary and that this information is accurate to the best of my knowledge. I authorize Lash Group, Inc. in its capacity on behalf of Bayer HealthCare Pharmaceuticals ("Lash Group") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information in this form to the insurer of the above-named patient and to obtain any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. As my business associate, Lash Group is required to comply with, and by its signature hereto, agrees that it will comply with the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

❒ I certify that Mirena therapy is medically necessary and that this information is accurate to the best of my knowledge. I authorize Lash Group, Inc. in its capacity on behalf of Bayer HealthCare Pharmaceuticals ("Lash Group") to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information in this form to the insurer of the above-named patient and to obtain any information about the patient, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or healthcare operation purposes. As my business associate, Lash Group is required to comply with, and by its signature hereto, agrees that it will comply with the applicable requirements of 45 CFR 164.504(e) regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise permitted by law.

Healthcare Provider Signature: _____ Date: _____

Lash Group Signature: _____ Date: _____

Patient

I authorize the Skyla or Mirena Reimbursement Support Programs to obtain information from my healthcare provider, insurance company, and other sources as deemed necessary to ensure the accuracy and completeness of understanding my coverage for Skyla or Mirena.

Patient Signature: _____ Date: _____

www.WHCSupport.com

Please see Important Safety Information for Skyla and Mirena on page 2 and full Prescribing Information for Skyla and Mirena.

BAYER

All Women OB/GYN, P.S.C.

IUD PAYMENT POLICY

Patient Name:_____ DOB:_____

This information is for patients desiring to have the Mirena® IUD, Liletta® IUD, Skyla® IUD or Paraguard® placed for birth control.

1) The cost of the Mirena and the Liletta devices are $1,000.00 , the Skyla and Paraguard devices are $800.00. We do ask for a credit/debit card number to hold in the event of a denial by your insurance company. **This will not be used unless there is a denial from your insurance company**.
***** There is a $ 50 restocking fee if insertion does not take place.**

2) **The $160.00 charge for the insertion**; will be discounted per your insurance contract with only the co-pay or deductible applied to the patient's cost.

3) **Follow-up charge of $ 80.00** does require a co-pay. This visit is to assure proper placement of the device for optimum effectiveness.

4) **3 D-Ultrasound w/Transvaginal Ultrasound charge of $ 330.00 & office visit of $80.00 :** could be charged if placement cannot be confirmed by manual exam.There would be a co-pay for the office visit and your particular policy may also require a co-pay/co-insurance for the Ultrasound.

5) **Removal of IUD charge of $ 175.00:** There would be a co-pay for this service.

6) **Removal of IUD charge of $ 175.00 & charge of $ 160.00 for Re-insertion of new IUD, in addition to cost of new IUD $1,000 or $800.00:** These charges would occur if you were having a removal and re-insertion done. A co-pay would be due for the office visit; and your insurance company may also require co-pays or co-insurance for the Ultrasounds.

Your signature below implies understanding and compliance with this policy:

_____
(Please print patient name)

_____ _____
Patient Signature Date

Revised: 09/01/2015