Check Reimbursement Request Authorization Form OCREVUS Co-pay Program

P.O. Box 2106 Morristown, NJ 07962
Phone: (844) 672-6729
Fax: (855) 672-6729
www.OCREVUScopay.com

Before you can use this form to request check reimbursement services, your practice must register to use the OCREVUS Co-pay Program. If you have not yet completed this one-time registration, please call OCREVUS Co-pay Program at (844) 672-6729.

This form must be completed in its entirety.

Note: Check reimbursements will be made payable and always sent to the "Check reimbursement payable to" name and "Street address" listed below.

Health Care Professional/Facility Information		
Practice name:		
Check reimbursement payable to:		
Street address:		
City:	State:	ZIP:
Phone number:	Fax number:	
Physicians' National Provider Identifier (NPI):		

Authorization	
I hereby authorize The Macaluso Group (TMG), on behalf of the OCREVUS Co-pay Program, to process and issue check reimbursements to the above-named facility for the above-named "Check reimbursement payable to" and sent to the above-named "street address". Furthermore, authorization is granted to correct inadvertent duplicate or overpayment transactions. It is acknowledged that neither Genentech USA, TMG nor their respective affiliates shall be responsible for any delay or loss of funds due to incorrect information submitted by me or any of the authorized representatives on the account. This authorization shall remain effective until notification is provided to TMG (at least ten [10] business days).	
Authorized signature:	
Printed name:	Date:
Your office will be contacted at the phone number provided above within 48 hours of receipt of this fax form if there are any issues.	

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