



Contact the MERZ CONNECT™ Support Line  
1-855-4MERZTX (1-855-463-7989), option 4  
Monday – Friday 8am – 7pm ET  
Fax 1-855-825-0488



## BENEFIT VERIFICATION FORM

### PATIENT INFORMATION

Patient First Name \_\_\_\_\_ Patient Last Name \_\_\_\_\_ MI \_\_\_\_\_  
Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Gender  M  F  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Preferred phone # \_\_\_\_\_  
Legal Guardian Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Legal Guardian Phone \_\_\_\_\_ Patient/Legal Guardian Email (Required) \_\_\_\_\_

### INSURANCE INFORMATION *(Please attach a copy of the front and back of the patient's insurance card)*

**PRIMARY Insurance Name** \_\_\_\_\_ Phone Number \_\_\_\_\_  
Policy holder \_\_\_\_\_ Policy holder ID # \_\_\_\_\_ Group ID # \_\_\_\_\_  
Policy holder Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Policy holder's Relationship to Patient \_\_\_\_\_  
**SECONDARY Insurance Name** \_\_\_\_\_ Phone Number \_\_\_\_\_  
Policy holder \_\_\_\_\_ Policy holder ID# \_\_\_\_\_ Group ID# \_\_\_\_\_  
Policy holder Date of Birth (MM/DD/YYYY) \_\_\_\_\_ Policy holder's Relationship to Patient \_\_\_\_\_

### HEALTHCARE PROVIDER INFORMATION

Healthcare Provider Name \_\_\_\_\_ Email \_\_\_\_\_  
Facility Name \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Ext # \_\_\_\_\_ Secure Fax # \_\_\_\_\_  
Office Contact Name \_\_\_\_\_ Office Contact Phone # \_\_\_\_\_  
National Provider Identification (NPI) # \_\_\_\_\_ State License # \_\_\_\_\_ Medicare Provider # \_\_\_\_\_  
Blue Cross Provider # \_\_\_\_\_ Group Tax ID # \_\_\_\_\_  
May we contact your patient?  Yes  No  
Place of Service *(check all to be verified)*  
 Physician Office (11)  Hospital Inpatient (21)  Ambulatory Surgical Center (21)  
 Hospital Outpatient (22)  Skilled Nursing (31)  Other *(Please Specify)* \_\_\_\_\_  
How will you supply the medication?  Buy and Bill  Specialty Pharmacy *(Name)* \_\_\_\_\_  
Place of Service Name *(if different from above)* \_\_\_\_\_ Address \_\_\_\_\_  
If the patient's insurer requires prior authorization, would you like assistance pursuing it?  Yes  No

Please scan the QR code on page 2 to see Important Safety Information, including BOXED WARNING, or visit [XEOMIN.com](http://XEOMIN.com) for Full Prescribing Information.



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Patient First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Date of Birth (MM/DD/YYYY) \_\_\_\_\_

## TREATMENT INFORMATION

Diagnosis Code 1 (ICD-10) \_\_\_\_\_ CPT Code 1 \_\_\_\_\_

Diagnosis Code 2 (ICD-10) \_\_\_\_\_ CPT Code 2 \_\_\_\_\_

95873 Electrical stimulation for guidance in conjunction with chemodenervation code

95874 Needle electromyographic guidance (EMG) in conjunction with chemodenervation code

76942 Ultrasound guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision, and interpretation

Injection Sites \_\_\_\_\_ # of Units Anticipated \_\_\_\_\_ Treatment Date (MM/DD/YYYY) \_\_\_\_\_

## HEALTHCARE PROVIDER CERTIFICATION

The MERZ CONNECT Support Line has been developed by Merz. The program is operated by Merz Pharmaceuticals, LLC (Merz), including by way of third party administrators, to help patients needing XEOMIN. A representative of the MERZ CONNECT Support Line may contact you for additional information.

By checking Yes below, you are certifying that the described therapy is medically necessary for the patient for which you are seeking access support and that you have received the necessary authorization from the patient/patient’s guardian to release the below referenced medical and/or other patient information relating to XEOMIN therapy to Merz and its third party administrators for the following purposes:

- To provide educational support in verifying patient/patient’s minor child’s insurance eligibility and coverage for XEOMIN (including medical and/or pharmacy benefit and specialty pharmacy options) and in seeking reimbursement for XEOMIN therapy;
- To assist in initiating and/or continuing XEOMIN therapy;
- To assess potential eligibility for patient/patient’s minor child’s participation in the XEOMIN Patient Savings Program and/or the XEOMIN Patient Assistance Program;
- To contact patient/patient’s minor child’s doctor and the rest of patient/patient’s minor child’s healthcare team and share with them pertinent health information that may be useful for care; and
- To improve, develop, and evaluate products, services, materials and programs related to patient/patient’s minor child’s condition or treatment.

By submitting this information, you certify that your patient has consented to your disclosure of the patient’s personal health information to Merz and its third party administrator for insurance verification and prior authorization support.

Healthcare Provider Certification  Yes  No

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