Bristol Myers Squibb™
Access Support®

Phone: 1-800-861-0048
Fax: X-XXX-XXX-XXXX
www.bmsaccesssupport.com

Benefits Review Results Form

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	RECORD ID:

PROVIDER INFORMATION

PRESCRIBER:

SITE NAME:

SITE OF SERVICE:

NETWORK STATUS:

TREATMENT INFORMATION

ICD CODE(S):

PAYER-SUGGESTED CPT CODE(S):

PAYER-SUGGESTED J CODE(S):

PRIMARY INSURANCE INFORMATION

PAYER NAME:	PAYER TYPE:	PAYER CONTACT:
PAYER PHONE:	PLAN NAME:	PLAN TYPE:
PRODUCT CO-PAY/CO-INSURANCE:	GROUP #:	POLICY #:
OFFICE CO-PAY/CO-INSURANCE:	POLICY RENEWAL DATE:	POLICY EFFECTIVE DATE:
ADMINISTRATION CO-PAY/CO-INSURANCE:	(OOP) MAX:	BENEFIT TYPE:
DEDUCTIBLE:	LIFETIME MAX:	☐ SELF-FUNDED ☐ FULLY-FUNDED

COVERAGE/PRIOR AUTHORIZATION INFORMATION *All claims subject to insurer review and approval.*

PRODUCT(S) NAME:

COVERAGE

☐ COVERED ☐ NOT COVERED

☐ COVERED WITH RESTRICTIONS ☐ UNDISCLOSED

PA REQUIREMENTS

PA REQUIRED: ☐ YES ☐ NO ☐ UNDISCLOSED

PRE-DETERMINATION SUGGESTED: ☐ YES ☐ NO

COVERAGE NOTES/DETAILS:

AUTHORIZATION INFORMATION:

PA ON FILE: ☐ YES ☐ NO ☐ PENDING

AUTH #:

PHONE: FAX:

PRODUCT ACQUISITION OPTIONS *List of SPPs may not include all available options. If preferred SPP is not listed, check with payer.*

☐ UNDISCLOSED

☐ BUY AND BILL

☐ SPECIALTY PHARMACY OPTIONAL

☐ SPECIALTY PHARMACY REQUIRED

OPTION 1

NAME: FAX:

PHONE:

OPTION 2

NAME: AUTH #:

PHONE:

NOTES/DETAILS:

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PATIENT INFORMATION

NAME:	DATE OF BIRTH:	RECORD ID:

SECONDARY INSURANCE INFORMATION

PAYER NAME:	PAYER TYPE:	PAYER CONTACT:	
PAYER PHONE:	PLAN NAME:	PLAN TYPE:	
PRODUCT CO-PAY/CO-INSURANCE:	GROUP #:	POLICY #:	
OFFICE CO-PAY/CO-INSURANCE:	POLICY RENEWAL DATE:	POLICY EFFECTIVE DATE:	
ADMINISTRATION CO-PAY/CO-INSURANCE:	(OOP) MAX:	BENEFIT TYPE:	
DEDUCTIBLE:	LIFETIME MAX:	☐ SELF-FUNDED	☐ FULLY-FUNDED

COVERAGE/PRIOR AUTHORIZATION INFORMATION *All claims subject to insurer review and approval.*

PRODUCT(S) NAME:

COVERAGE

☐ COVERED ☐ NOT COVERED
☐ COVERED WITH RESTRICTIONS ☐ UNDISCLOSED

PA REQUIREMENTS

PA REQUIRED: ☐ YES ☐ NO ☐ UNDISCLOSED
PRE-DETERMINATION SUGGESTED: ☐ YES ☐ NO

COVERAGE NOTES/DETAILS:

AUTHORIZATION INFORMATION:

PA ON FILE: ☐ YES ☐ NO ☐ PENDING
AUTH #:
PHONE: FAX:

PRODUCT ACQUISITION OPTIONS *List of SPPs may not include all available options. If preferred SPP is not listed, check with payer.*

☐ UNDISCLOSED
☐ BUY AND BILL
☐ SPECIALTY PHARMACY OPTIONAL
☐ SPECIALTY PHARMACY REQUIRED

OPTION 1
NAME:
PHONE:

OPTION 2
NAME:
PHONE:

NOTES/DETAILS:

ADDITIONAL COMMENTS

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NAME:	DATE OF BIRTH:	RECORD ID:

LIST OF THIRD-PARTY CHARITABLE FOUNDATIONS *The foundation(s) listed are independent from Bristol-Myers Squibb Company and have their own eligibility criteria and evaluation process. Bristol Myers Squibb cannot guarantee that a patient will receive assistance.*