MEDICAL CLAIM FORM

EntyvioCONNECT | Entyvio vedolizumab

Submit with **Primary Insurance EOB** via fax to 844-595-6272

Date of Service:	**Co-pay MemberID:**	**Co-Pay Group Number:**

Section 1: Patient Information (* required information)

First Name*		Last Name*		Middle Name	
Address 1*					
Address 2					
City*		State*		Zip*	
Gender*	☐ M ☐ F ☐ U	DOB*		Phone Number*	
Best time to contact	☐ Morning ☐ Afternoon ☐ Evening	Email			
Relationship to insured*		☐ Self ☐ Spouse ☐ Other Dependent			

Section 2: Insured Information (* required information only if different than Patient)

First Name*		Last Name*		Middle Name	
Address 1*					
Address 2					
City*		State*		Zip*	
Gender*	☐ M ☐ F ☐ U	DOB*		Phone Number*	

Section 3: Billing Practice Information (* required information)

Practice Name*		Tax ID*		NPI*	
Address 1*					
Address 2					
City*		State*		Zip*	
Phone*		Email*		Fax*	

Section 4: Treating Physician/Provider Information (*required information)

First Name*		Last Name*		Middle Name	
Specialty		Title		NPI*	

Section 5: Payee (To Be Mailed to the Address Above)

☐ Patient ☐ Billing Practice

Please click here to read the full Prescribing Information, including Medication Guide.

Q CODE / BAR CODE

 US-VED-1124v1.0 10/21