



## *Fertility Drug Benefit Pre-Verification Form (v11.06.2)*

We, in conjunction with Damer & Cartwright Specialty Pharmacy, are pleased to offer a free service to patients to help uncover their fertility drug benefits, even before treatment begins.

We, the staff at ARHC, are excited to offer this program to our patients. Here's all you need to do to start the process:

1. Complete the attached form, "Fertility Drug Benefit Pre-Verification Fax Form."
2. If you have a separate Prescription Drug card, be sure you present it to the front desk staff.
3. Damer & Cartwright Pharmacy's insurance staff will verify your fertility medication coverage as follows:
  - a.) Does the patient have any fertility medication coverage?
  - b.) If yes, what pharmacies can fill the prescriptions?
  - c.) What medications, if any, require a prior authorization?
  - d.) If yes, who does the prior authorization?
  - e.) What is the patient's out of pocket expense for the medications?
  - f.) Is there a maximum amount the plan will pay for the fertility medications?
  - g.) If yes, what is the amount and how much has been used (or remains)?
4. A letter will be mailed to you with the results of our inquiry regarding your drug benefits.  
A copy will be filed in your medical record.

By signing this notification, I authorize the staff at ARHC, Ltd / Chicago-IVF to forward my Pharmacy Benefit information to Damer & Cartwright Pharmacy. My signature also authorizes Damer & Cartwright Pharmacy to verify my fertility medication coverage.

I have the option to not sign this form. If I choose not to sign this form, I understand that it is my responsibility to verify my own Pharmacy Benefits. Either way, I will need to notify the nursing staff at ARHC this information once the verification is complete.

X \_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Witness Signature (*Clinic Staff Member*)

\_\_\_\_\_  
Date



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*Fertility Drug Benefit  
Pre-Verification Facsimile Form (v11.06.2)*

To \_\_\_\_\_ Fax No. \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_

Please send results to:

ARHC Office \_\_\_\_\_ Fax No. \_\_\_\_\_ Attention \_\_\_\_\_

**TO BE COMPLETED BY PATIENT:**

Patient's Name \_\_\_\_\_ Patient's D.O.B. \_\_\_\_\_

Patient's Social Security # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Employer Group \_\_\_\_\_

Insured's D.O.B. \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

*(If Applicable)*

Patient's Address \_\_\_\_\_  
\_\_\_\_\_

**Patient's Phone #s:**

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

I, \_\_\_\_\_ understand that Damer & Cartwright Pharmacy will assist in verifying my pharmacy fertility medication benefits. The benefit results will be sent directly to you, the patient, and a copy will be forwarded to my medical records at ARHC, Ltd.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

ARHC, Ltd./Chicago IVF and Damer & Cartwright are all HIPPA compliant and any personal information you provide us will be kept strictly confidential according to HIPPA privacy laws.

ARHC, Ltd. Staff \_\_\_\_\_

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