Attn: Claims Processing Dept.
430 Mountain Ave., Suite 105
New Providence, NJ 07974
Phone: 800-519-2140
Fax: 908-548-9247

Stemline Savings Program
Claims Submission Form

Healthcare Provider, please fax or mail this form along with a detailed explanation of benefits* (EOB) and either the CMS1500 or UB04 to the fax number or address above to request payment from the program toward the cost of the product.

Patients seeking reimbursement, please fax or mail this form along with a detailed explanation of benefits (EOB) to the fax number or address above to request payment from the program toward the cost of the product.

Patient Name: _____ **Date of Birth:** _____

Patient ID: _____ **Phone:** _____

Alternate Contact: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Provider Name: _____

Reimbursement Payable To: □ **Patient** □ **Provider** □ **Other**

Payee Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Service: _____ **Amount Requested:** _____

Patient Signature: _____ **Date:** _____

*A detailed EOB includes insurance carrier name and logo, name of the plan, patient's responsibility, date of service and drug code broken out by name, J-Code, or National Drug Code (NDC).