

BMS Access Support Co-Pay Assistance Check Request Form

Fax or mail this form along with a detailed explanation of benefits* (EOB) to the fax number or email above to request payment from the program. If you are requesting reimbursement to anyone other than the provider, please also include a copy of the receipt confirming payment to your health care provider.

Patient Name* _____ Date of Birth* _____

Member 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 procedure code broken out by name, CPT or HCPCS Code. CPT and HCPCS codes are used by providers to identify a medical procedure for billing. A CPT code is a 5-digit numerical code that starts with the number 9. A HCPCS codes is a 5-digit codes that starts with a J followed by 4 numerical digits.*