Novo Nordisk Savings Offer Reimbursement

PO Box 2355 | Morristown, NJ 07962 | Attn: Claims Processing

Please complete this form and submit with all required information and attachments to be considered for reimbursement.

Please be aware that the refund may take several weeks to receive. To be eligible, patients must submit a receipt from their pharmacy showing that they have paid the full medication out-of-pocket costs with their insurance plan. Claims for patients enrolled in any federal or state health care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program, are INELIGIBLE for reimbursement.

Mail this completed form and the information below to:
Novo Nordisk Claims Processing Dept., PO Box 2355, Morristown, NJ 07962

1. The original proof of purchase (original pharmacy receipt with pharmacy name, product name, NDC, prescription number or Rx#, date filled, quantity, and the overall price and copay/out-of-pocket expense paid)
2. A legible photocopy of the front of the patient's primary Rx insurance card or provide the name of the patient's primary prescription insurance along with BIN and PCN information found on the card
3. The patient's name, address, city, state, ZIP code, phone number, date of birth, and the out-of-pocket payment
4. A photocopy of the savings offer or the 10-digit GRP# (beginning with EC and AC) and 11-digit ID# that is found on the savings offer

Please allow 6-8 weeks to receive your reimbursement. Reimbursements are subject to the program terms, conditions, and eligibility criteria. Requests must be received within 180 days from the date the prescription was filled. Medication filled prior to enrollment in this program will not be eligible for copay assistance and cannot be reimbursed.

Part I–Patient information

First name | Last name | Date of birth

Street address | Apt/suite no. | City

State | ZIP code | Phone number | Email

Part II–Medication and savings offer information

Name of Novo Nordisk medication you are submitting a claim for

GRP#: | | | | | | | | | | | ID#: | | | | | | | | | | | |

10-digit GRP# (beginning with EC and AC) and 11-digit ID# is found on your savings offer.

Part III–Prescription insurance information

Primary Rx payer/Rx insurance name | Primary Rx insurance BIN | Primary Rx insurance PCN

Amount paid by insurance | Amount paid by the patient ("copay")

Part IV–Pharmacy information

Pharmacy name | Pharmacy phone number

Pharmacy street address | Pharmacy city | Pharmacy state | Pharmacy ZIP code

Part V–Certification statement

"I certify that the information provided in this claim is accurate, that expenses requested for payment here were eligible, actually incurred, and that they were not and will not be paid by my insurance. I certify that I am not enrolled in any federal or state care program with prescription drug coverage, such as Medicaid, Medicare, Medigap, VA, DOD, TRICARE, or any similar federal or state health care program (each a Government Program), or where prohibited by law, and that I meet all the terms, conditions, and eligibility requirements of the savings offer."

In support of my claim for reimbursement of my pharmacy expenses, I authorize Novo Nordisk and its agents to contact my pharmacy to disclose information about the pharmacy claim for which I am seeking reimbursement.

A copy of this authorization is as valid as the original, and this authorization will be valid even if I sign it electronically.

Claimant/Patient/Legal Guardian Signature | Date

Failure to complete this request in its entirety will result in claim rejection.