Claims Department
P.O. Box 845
Stevens Point, WI 54481-0047
Toll Free: 1-866-330-7902

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with your Pfizer Pledge™ Warranty Program.

PFIZER PLEDGE™
PATIENT WARRANTY CLAIM FORM
(TO BE COMPLETED BY THE PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE)

CLAIM NO:

IMPORTANT NOTE:
Please complete all sections to facilitate the processing of this form.
Please answer all questions. An incomplete form may cause a delay in our assessment of your claim. Please either type your responses or print clearly. *Coverage is provided by New Hampshire Insurance Company, an AIG Company. Coverage is subject to certain terms, conditions, and limitations, including limitations on the amount of coverage.*

To enable us to process your claim expeditiously, please return the completed claim form with supporting documents as listed in the subsequent section. Please direct the claim form and all correspondence to:

AIG Claims, Inc.
PO Box 845
Stevens Point, WI 54481
Tel: 1-866-330-7902
Email: PfizerPledge@AIG.com
Fax: 1-715-342-2490

All benefits are paid in accordance with the terms and conditions of the Group Policy. The acceptance of this claim form is NOT an admission of liability on the part of AIG Claims, Inc. Any documentary proof or report required to process this claim shall be furnished at the expense of the Patient. *This Group Policy is underwritten by New Hampshire Insurance Company, an AIG Company, and benefits are provided to you as part of Pfizer Pledge.*

Documents Required:

- **Signed and completed Patient Warranty Claim Form**
- **Copy/photo of both sides of your insurance card(s) for both prescription and medical insurance**
- **Copy/photo of your pharmacy receipts or insurance Explanation Of Benefits (EOB) to prove what you paid for your XALKORI® prescription out of your own pocket (NOTE: If you do not have this information, it can be obtained by contacting your pharmacy or insurer)**
- **Signed and completed Patient Declarations and Authorizations Form**
- **Signed Physician Attestation Form from your XALKORI prescribing physician confirming the following:**
    - **Your name, date of birth**
    - **Reason XALKORI was prescribed**
    - **Clinical rationale for discontinuance of XALKORI**

PATIENT INFORMATION	
Patient's Name (First, Middle, Last)	Patient Date of Birth (MM/DD/YYYY):
Patient Address (Street, City, State, Zip)	Patient Sex (Male or Female)
Patient Primary Phone (with area code)	Patient Secondary Phone (with area code)
Patient Primary Email Address	Patient Secondary Email Address

Patient Preferred Language (if not English):			
Communications Preferences: How would you like to receive claims status updates? (check all that apply)	Phone	Email	Mail

AUTHORIZED PATIENT REPRESENTATIVE INFORMATION (IF APPLICABLE)	
Name (First, Middle, Last)	Address (Street, City, State, Zip OR if same as Patient, write "SAME")
Primary Phone (with area code)	Primary Email Address

HEALTH INSURANCE INFORMATION		
Has your Health Insurance for XALKORI changed since you initiated your first dose and when you discontinued therapy? (select one) **If YES, complete both SECTION 1 AND SECTION 2 below.**	Yes	No

NOTE: In addition to the information below, please provide copy/photo of both sides of your medical and prescription insurance card(s)

Health Insurance Section 1			
Which dispenses were covered with this insurance (select all that apply)	Dispense 1	Dispense 2	Dispense 3

Primary Insurance (from your Primary Insurance Card)				
Primary Insurance Type (select one)	Commercial	Medicare Part D	Other (e.g. Medicaid)	None

Primary Insurer Name	Primary Insurer Member Phone (with area code)
Primary Insurer Address on Insurance Card (Street, City, State, Zip)	
Policy/Medicare Beneficiary ID#	Group ID #

Policyholder same as patient? (select one)	Yes	No	Policyholder relationship to Patient (if Patient, write "PATIENT")
Policyholder Name			Policyholder Date of Birth (MM/DD/YYYY)

Secondary Insurance (from your Secondary Insurance Card)				
Secondary Insurance Type (select one)	Commercial	Medicare Part D	Other (e.g. Medicaid)	None

Secondary Insurer Name	Secondary Insurer Member Phone (with area code)
Secondary Insurer Address on Insurance Card (Street, City, State, Zip)	
Policy/Medicare Beneficiary ID#	Group ID #

Policyholder same as patient? (select one)	Yes	No	Policyholder relationship to Patient (if Patient, write "PATIENT")
Policyholder Name			Policyholder Date of Birth (MM/DD/YYYY)

Prescription Insurance (if you have a separate Card for Prescription Insurance)		
Prescription Insurance Name	Prescription Policy ID#	
Prescription Group #	Prescription BIN #	Prescription PCN#

Complete this section only if you are enrolled in a Medicare Part D Prescription Drug Plan	
Medicare Part D Plan Name	Medicare ID Number (HICN) or Medicare Beneficiary Number (MBI)
Medicare Part D Plan Address on Insurance Card (Street, City, State, Zip)	

Health Insurance Section 2 – To be completed ONLY if your insurance CHANGED while taking XALKORI				
Which dispenses were covered with this insurance (select all that apply)	[redacted]		Dispense 2	Dispense 3
Primary Insurance (from your Primary Insurance Card)				
How many XALKORI dispenses occurred using this insurance? (select one)	The second and third dispenses		Only the third dispense	
Primary Insurance Type (select one)	Commercial	Medicare Part D	Other (e.g. Medicaid)	None
Primary Insurer Name		Primary Insurer Member Phone (with area code)		
Primary Insurer Address on Insurance Card (Street, City, State, Zip)				
Policy/Medicare Beneficiary ID#		Group ID #		
Policyholder same as patient? (select one)	Yes	No	Policyholder relationship to Patient (if Patient, write "PATIENT")	
Policyholder Name		Policyholder Date of Birth (MM/DD/YYYY)		
Secondary Insurance (from your Secondary Insurance Card)				
Secondary Insurance Type (select one)	Commercial	Medicare Part D	Other (e.g. Medicaid)	None
Secondary Insurer Name		Secondary Insurer Member Phone (with area code)		
Secondary Insurer Address on Insurance Card (Street, City, State, Zip)				
Policy/Medicare Beneficiary ID#		Group ID #		
Policyholder same as patient? (select one)	Yes	No	Policyholder relationship to Patient (if Patient, write "PATIENT")	
Policyholder Name		Policyholder Date of Birth (MM/DD/YYYY)		
Prescription Insurance (if you have a separate Card for Pharmacy Insurance)				
Prescription Insurance Name		Prescription Policy ID#		
Prescription Group #	Prescription BIN #		Prescription PCN#	
Complete this section only if are enrolled in a Medicare Part D Prescription Drug Plan				
Medicare Part D Plan Name		Medicare ID Number (HICN) or Medicare Beneficiary Number (MBI)		
Medicare Part D Plan Address on Insurance Card (Street, City, State, Zip)				
XALKORI PRESCRIBING PHYSICIAN INFORMATION				
Prescribing Physician Name (First, Middle, Last)		Prescribing Physician Office Phone (with area code)		
Prescribing Physician Address (Street, City, State, Zip)				
XALKORI DISPENSING PHARMACY INFORMATION				
Dispensing Pharmacy Name		Dispensing Pharmacy Phone (with area code)		
Dispensing Pharmacy Address (Street, City, State, Zip)				

DISPENSE 1 INFORMATION (NOTE: The pharmacy that dispensed XALKORI should be able to provide you with this information)			
Prescription number (Rx number)	Date of dispense	Dose dispensed (250mg or 200mg)	
Number of Pills Dispensed	Days of Supply		
Did you receive financial assistance from the Pfizer Oncology Together Co-Pay Savings Program for XALKORI? (check one)		Yes	No
Did you receive co-pay financial assistance from a patient assistance program based on financial need (check one)		Yes	No
Total co-pay amount due at time of dispense, inclusive of any medication co-pay financial assistance)	**Patient Out-of-Pocket Amount (actual $ paid)**		
DISPENSE 2 INFORMATION			
Prescription number (Rx number)	Date of dispense	Dose dispensed (250mg or 200mg)	
Number of Pills Dispensed	Days of Supply		
Did your dispensing pharmacy change? (check one)		Yes	No
Did you receive financial assistance from the Pfizer Oncology Together Co-Pay Savings Program for XALKORI? (check one)		Yes	No
Did you receive co-pay financial assistance from a patient assistance program based on financial need (check one)		Yes	No
Total co-pay amount due at time of dispense, inclusive of any medication co-pay financial assistance)	**Patient Out-of-Pocket Amount (actual $ paid)**		
DISPENSE 3 INFORMATION			
Prescription number (Rx number)	Date of dispense	Dose dispensed (250mg or 200mg)	
Number of Pills Dispensed	Days of Supply		
Did your dispensing pharmacy change? (check one)		Yes	No
Did you receive financial assistance from the Pfizer Oncology Together Co-Pay Savings Program for XALKORI? (check one)		Yes	No
Did you receive co-pay financial assistance from a patient assistance program based on financial need (check one)		Yes	No
Total co-pay amount due at time of dispense, inclusive of any medication co-pay financial assistance)	**Patient Out-of-Pocket Amount (actual $ paid):**		