Claims Department
P.O. Box 845
Stevens Point, WI 54481-0047
Toll Free: 1-800-276-0726

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™ WARRANTY PROGRAM
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.
If your primary health insurance or pharmacy changed during the course of your treatments, complete a separate claim form for each.
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 send the claim form and all correspondence to:

AIG Claims, Inc.
P.O. Box 845
Stevens Point, WI 54481
Tel: 1-800-276-0726
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.*

For details about how Pfizer collects and uses personal information, including applicable US state privacy rights and notices for California residents, please visit www.pfizer.com/privacy.

Documents Required:

1. **Copy/photo of both sides of your insurance card(s) for both prescription and medical insurance**
2. **Copy/photo of the Explanation of Benefits (EOB) for each treatment from your Health Insurer(s)**
3. **Signed and completed Patient Warranty Claim Form**
4. **Signed and completed Patient Declarations and Authorizations Form**
5. **Signed and completed Physician Attestation Form from your PANZYGA-prescribing physician**
6. **Signed and completed Pharmacy Attestation Form from your PANZYGA-dispensing pharmacy or outpatient clinic**

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
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 PANZYGA 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 Treatments Were Covered with This Insurance? (select all that apply)	Treatment 1 ☐	Treatment 2 ☐	Treatment 3 ☐	Treatment 4 ☐

Primary Insurance (from your Primary Insurance Card)

Primary Insurance Type (select one)	Commercial ☐	None ☐	
Primary Insurer Name		Primary Insurer Member Phone (with area code)	
Primary Insurer Address on Insurance Card (Street, City, State, ZIP)			
Policy 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 ☐	None ☐	
Secondary Insurer Name		Secondary Insurer Member Phone (with area code)	
Secondary Insurer Address on Insurance Card (Street, City, State, ZIP)			
Policy 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 #

PANZYGA-PRESCRIBING PHYSICIAN INFORMATION

Prescribing Physician Name (First, Middle, Last)	Prescribing Physician Office Phone (with area code)
Prescribing Physician Address (Street, City, State, ZIP)	

PANZYGA-DISPENSING/INFUSING PHARMACY OR OUTPATIENT CLINIC INFORMATION

Dispensing Pharmacy Name	Dispensing Pharmacy Phone (with area code)
Dispensing Pharmacy Address (Street, City, State, ZIP)	