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The Confidence in Coverage Program Form

Following insertion, if your patient has been denied coverage* by her plan, use this form to apply for a replacement IUD at no cost for any insertions dated within 1 year of coverage denial as shown on Explanation of Benefits [EOB]. This program is valid for US patients only.**

Section 1: To be completed by Bayer Sales Specialist

Select Product (Check one): ☐ Kyleena® ☐ Mirena® ☐ Skyla®			
BHOID:	Date:		
Bayer Sales Specialist:		CWID:	Cell #:
HCP First Name:	Last Name:	BHID:	Office Contact:
Facility Name:		Office Phone:	
Facility Address:			
City:		State:	Zip:

Ship IUD Unit To: ☐ Facility Address *(will be shipped to address as noted above)*

☐ Bayer Representative Address *(please provide, if different from above)* _____ Address _____ City _____ State _____ Zip

Section 2: To be completed by HCP Office

Patient Plan Type (Check one): ☐ **Commercial** ☐ **Government (i.e. Medicaid)**		
Plan Name:		
Patient Initials:	Birth Year:	Insertion Date:
Denial of Coverage Date:	Lot #:	Lot Expiration Date:
Reason for denial of coverage:		
Copy of deidentified denial of coverage EOB (Explanation of Benefits) provided: ☐ Yes ☐ No		***NOTE: EOB is REQUIRED for approval***

Submit your form to - Fax: 862-404-3036 or email to: ConfidenceInCoverage@bayer.com

Section 3: To be completed by HCP Office

[HCP must sign the following certification – if requesting a free unit]

☐ **The HCP certifies that (i) the unit for which the HCP now seeks replacement is a FDA-approved product, manufactured and distributed by Bayer or its authorized affiliates or contractors, (ii) the unit for which the HCP seeks replacement was completely denied coverage by the patient's payor, and (iii) the HCP will not appeal the denial and will not seek or accept any reimbursement from any public or private third party payer or payment from the patient for the denied unit.**

Print HCP Name: _____ License No. _____

If signing on behalf of provider, check this box:

Name: _____ **Title:** _____

Signature: _____ Date: _____

For Internal Documentation Only	☐ Approved	☐ Denied
Reason for Denial:		

*Does not apply for patients that have cost-sharing, copayments, insertion and removal costs, or any other costs.
**Intrauterine Device

Kyleena® (levonorgestrel-releasing intrauterine system) 19.5 mg | Mirena® (levonorgestrel-releasing intrauterine system) 52 mg | Skyla® (levonorgestrel-releasing intrauterine system) 13.5 mg