



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 May 13, 2019 and onward.

Section 1: To be completed by Bayer Sales Specialist

Select Product (Check one):				<input type="checkbox"/> Kyleena®	<input type="checkbox"/> Mirena®	<input type="checkbox"/> 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: <input type="checkbox"/> Facility Address (will be shipped to address as noted above)						
<input type="checkbox"/> 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):				<input type="checkbox"/> Commercial	<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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]	
<input type="checkbox"/> 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: <input type="checkbox"/>	
Name: _____	Title: _____
Signature: _____	Date: _____
For Internal Documentation Only <input type="checkbox"/> Approved <input type="checkbox"/> Denied	
Reason for Denial:	

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

**Intrauterine Device



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Kyleena®
(levonorgestrel-releasing
intrauterine system) 19.5 mg

Mirena®
(levonorgestrel-releasing
intrauterine system) 52 mg

Skyla®
(levonorgestrel-releasing
intrauterine system) 13.5 mg