

Benefits Analysis Form

First Name:

Last Name:

DOB :

SSN:

Daytime phone:

Cell phone:

Address:

City, State, ZIP:

Physicians name:

Physicians phone:

Medications to verify: please check the appropriate boxes

- Follistim**
- Bravelle**
- Menopur**
- Gonal F**
- Repronex**
- Luveris**
- Ganirelix**
- Cetrotide**
- Lupron 2 week kit/Leuprolide Acetate**
- HCG/Novaryl**
- Ovidrel**
- Endometrin**
- Crinone**
- Progesterone in oil**
- Other. Text box**

Medications needed by: mm/dd/yy

Pharmacy Insurance Information

please look for your drug/pharmacy card, not your medical card

Primary Policy Holder: Last Name First Name

Bin#

ID#

PCN#

Group#

Pharmacy Contact Phone/Pharmacy Helpline:

Name of Insurance Company:

If you are not the primary policyholder, please complete:

Primary Name:

Primary DOB:

Primary SSN:

I have secondary insurance.