SEARCHLIGHT SUPPORT®

Out-of-Pocket Assistance Program

Request for Co-payment Assistance Fax Cover Sheet

Patient Name: <PATIENT NAME>

Patient Date of Birth: <PATIENT DOB>

Patient ID: <PATIENT ID>

Please use this form as a cover sheet with **each** out-of-pocket request for co-payment assistance you submit by fax.

Provide all required documents as outlined in the *Searchlight Support® Out-of-Pocket Assistance Program* (the Program) brochure for healthcare providers and on the back of the program card and fax to 1-919-562-0021 or mail to the following address:

SEARCHLIGHT SUPPORT®
PO BOX 1349
WAKE FOREST, NC 27588

Eligible claims will be processed upon receipt. Please allow several business days for receipt of payment.

If you have any questions about the Program, please call 1-844-SRCHLGT (1-844-772-4548), Monday-Friday, 8:00 AM–8:00 PM ET.

If you do not wish to receive any faxes from Searchlight Support® in the future, call 1-844-SRCHLGT (1-844-772-4548), Monday-Friday, 8:00 AM–8:00 PM ET or by fax at 1-888-782-6157. We will not honor your request if: **1.** It is not made to the phone or fax number provided; **2.** It doesn't identify the telephone number(s) at which you no longer wish to receive faxes; or **3.** After making this request, you provide express invitation or permission to the sender, in writing or otherwise, to send such communications to you. Our failure to comply with an opt-out request within 30 days is unlawful.

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