We Pay The Difference Enrollment Form

OMIDRIAssure®
SUPPORT AT EVERY STEP

The Explanation of Benefits (EOB) for the patient(s) listed below have been provided to the OMIDRIAssure® program for review. To provide reimbursement support (reimbursement is never guaranteed) for these patients and process payment for the "We Pay The Difference" program (if applicable for commercially insured patients), Rayner requires the Office Certification at the bottom of this form to be signed. Please have an individual with signing authority sign and fax the form to the OMIDRIAssure program at 1-855-664-3741. Important: "We Pay The Difference" requests for commercial insurance must be submitted within 90 days of the service date. Requests received after 90 days will be automatically denied.

Patient Information

First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:
First Name:	Last Name:	DOB:	Date of Surgery:	Physician Name:	Member ID#:

Facility Name: ______ Facility Address: ______

Facility Phone Number: ______ Facility Email Address: ______

Office Certification

By signing below, I certify that the patient(s) named above is/are my patient(s) or the patient(s) of this surgery center, and that the information provided is, to the best of my knowledge, complete and accurate. I confirm that each patient's authorization has been obtained, to disclose their personal and health information to the OMIDRIAssure® program's purveyor for use in connection with potential patient and reimbursement support services. I consent to Rayner's representatives and agents contacting me and this surgery center to confirm receipt of OMIDRIA or to provide additional information about OMIDRIA and the OMIDRIAssure program. Upon receipt of payment from the OMIDRIAssure program, I and this surgery center agree to promptly return any copay or coinsurance collected from the patient(s) named above for OMIDRIA. I acknowledge that Rayner may change or terminate any of the OMIDRIAssure program services at any time without notice.

Signature: ______ Date: ______

Signatory Name / Title: ______

Please fax completed and signed form to 1-855-664-3741

The "We Pay The Difference" commercially Insured Patient Reimbursement Program patient benefit is not available for patients with any government insurance. Facility acquisition cost is determined after application of any discount or rebate.

Rayner

OMIDRIA®
(phenylephrine and ketorolac intraocular solution) 1% / 0.3%