AMGEN FIRST STEP™

CHECK REQUEST FORM

Please complete all required information [*]

1 Patient Enrollment Confirmation

*Patient First Name _____ *Patient Last Name _____

*Amgen FIRST STEP Member ID (Found on member's card) _____

Patient Mailing Address _____ Apartment / Unit / Suite _____

City _____ State _____ Zip _____

2 Physician and Practice Confirmation

*Physician First Name _____ *Physician Last Name _____

*Practice Name and Location _____

Practice Mailing Address _____ Apartment / Unit / Suite _____

City _____ State _____ Zip _____

3 Check Information

*Check Recipient (Please check one) ☐ Patient ☐ Practice

The check will be mailed to the address provided for the marked recipient. Please make sure to provide the corresponding address in this form.

*Date(s) of Service (mm/dd/yyyy) _____

*Amount Requested _____ *Signature _____

*In addition to the documentation required by the program, when selecting "Patient" as a check recipient, make sure to include **proof of payment** as part of the document submission.*

Preferred Fax-Back Number for Notification (Optional) _____

Entering a fax number here indicates you would like to receive fax confirmation that the check has been sent to the address provided.

Please send the completed form along with Explanation of Benefits (and Proof of Payment, if required) to:

- **FAX: 1-800-675-2661**

or

- **MAIL TO: 100 Passaic Ave, Suite 245, Fairfield NJ 07004**

Attention: The Amgen FIRST STEP™ Program

*Subject to program eligibility requirements and coverage limits, which can be found at https://amgenfirststep.com/who-is-eligible for details. This program is not open to patients receiving prescription reimbursement under any federal, state, or government-funded healthcare program, such as Medicare, Medicare Advantage, Medicare Part D, Medicaid, Medigap, Veterans Affairs (VA), the Department of Defense (DoD) or TRICARE® or where otherwise prohibited by law. The facsimile transmission and accompanying documents contain information that is confidential or privileged. This information is intended for the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure copying, distribution, or use of contents of this faxed information is strictly prohibited. If you received this fax in error please, notify us by telephone (1-888-657-8371) so that we can arrange for the return of the original documents to us and the retransmission of them to the intended recipient. Patients must meet all eligibility requirements to qualify. For program details, please visit www.AmgenFIRSTSTEP.com or call 1-888-65-STEP1 (1-888-657-8371).

The AMGEN FIRST STEP™ Program