



# Insurance Verification Sample Results Form

**Service request number:**  
 • Unique number assigned by SYNVISIC Connection and should be used when contacting SYNVISIC Connection

**Code:**  
 • This will always be J7325 for Synvisc-One and SYNVISIC and 20610 for the administration


**Deductible:**  
 • Dollar amount per year and dollar amount met so far this year

**Co-payment and/or coinsurance:**  
 • Dollar or percentage amount that the patient is responsible for paying

**Out-of-pocket maximum:**  
 • Annual out-of-pocket dollar amount patient is responsible for, and amount met so far this year

**Prior Authorization (PA):**  
 • Identifies if PA is required by payer, includes PA requirements, where to submit, and the estimated turnaround time from the payer

**Additional information:**  
 • Any additional detail about the patient's plan or the outcome



**SYNVISIC Connection**  
 Synvisc-One® Insurance Verification (IV) Results

Phone: (800) 982-8292  
 Fax: (800) 508-8083  
[www.SynviscOne.com/reimbursement](http://www.SynviscOne.com/reimbursement)

The SYNVISIC Connection is offered as an information service only. Please keep in mind that this information represents a summary of what the insurer told us. Third-party payment is affected by many factors; therefore, you should not interpret this letter as a guarantee of coverage or reimbursement now or in the future. Genzyme does not ensure the accuracy of this information and makes no representation or guarantee that you will be successful in obtaining insurance reimbursement.

<p><b>To:</b> Susie Office Contact</p> <p><b>Physician Name:</b> Joe Doctor</p> <p><b>Fax Number:</b> (555) 555-1234</p> <p><b>Patient Name:</b> Jane Doe</p> <p><b>Insurance Company:</b> Payer Name</p> <p><b>Insurance Policy Number:</b> ABC123</p> <p><b>Insurer Phone:</b> (800) 237-2767</p>	<p><b>From:</b> SYNVISIC Connection Agent Name</p> <p><b>Service Request Number:</b> 1-2345678</p> <p><b>Date:</b> 1/26/2011</p> <p><b>Date of Birth:</b> 01/01/1951</p> <p><b>Referral Required:</b> Required (details below) <input type="checkbox"/> Not Required <input checked="" type="checkbox"/></p> <p><b>Referring MD:</b> N/A</p> <p><b>Referring MD Phone:</b> N/A</p>
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SYNVISIC CONNECTION Insurance Research Results for Payer Name and policy number ABC123		
<b>Billing/Admin Code</b>	J7325	20610
<b>Setting</b>	Provider's Office	Provider's Office
<b>Benefit Type</b>	Major Medical	Major Medical
<b>Coverage Outcome</b>	Prior Authorization Required	Prior Authorization Required
<b>Reimbursement Amount</b>	100% of Fee Schedule	100% of Fee Schedule
<b>Deductible</b>	N/A	N/A
<b>Copayment and/or Coinsurance</b>	0% Coinsurance	0% Coinsurance
<b>Out of Pocket Maximum</b>	N/A	N/A

**Office Visit Copayment:** N/A

**Plan Limitations and Restrictions:** Provider Must Buy and Bill

<b>Prior Authorization Information</b> Required (please see details below) <input type="checkbox"/> Not Required <input checked="" type="checkbox"/>	
Contact SYNVISIC Connection if you would like assistance with the prior authorization.	
<b>Submission Method:</b>	<b>Estimated Completion Time:</b>
<b>Insurer PA Fax Number:</b>	<b>Insurer PA Phone Number:</b>
<b>Required Information:</b>	

**Additional Information:** The patient's plan does not allow for SPP, which means the provider must Buy and Bill for the product. As a courtesy, SYNVISIC Connection has completed an Insurance Verification for your office to Buy and Bill.

Visit SYNVISIC Connection at [www.SynviscOne.com/reimbursement](http://www.SynviscOne.com/reimbursement) to access the electronic version of the Patient Access Form, as well as obtain additional coverage, coding and reimbursement information for Synvisc-One.

For demonstration use only. Actual patient coverage will differ on a case-by-case basis.

