

LETTER TO HEALTH PLAN
MAIL COMPLETED LETTER TO YOUR INSURANCE PLAN



To whom it may concern:

I am an enrollee in your prescription drug plan, and this letter is to advise you that I have been prescribed the medication listed below by my physician. I am purchasing this product outside of my insurance benefit with the Pfizer Self-Pay Program sponsored by Pfizer, Inc (the "Program").

This letter is not a request for reimbursement, as I have agreed to not seek reimbursement for my purchase in accordance with the Terms & Conditions of this Program. As an enrollee of a state and/or federally funded healthcare insurance program, I may not submit any claims for reimbursement for prescriptions purchased as part of this Program. Additionally, the Program prohibits these prescription expenses from counting toward any out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP). I also agree that I will not utilize state and/or federal healthcare insurance coverage for the specified product below throughout the entire calendar year consistent with the Program Terms & Conditions.

If you have questions about this medication or the Program, please contact Pfizer at 1-877-321-4255, Monday to Friday from 8 AM to 5 PM E.T.

Sincerely,

Name	
Date	
Date of Birth	
Plan	
Plan Membership ID	
Pfizer Medication	