Solesta Temporary Rebate Initiative Request Form

Phone: 844-350-9656 **Fax:** 513-506-7361
PO Box 428710 Cincinnati, OH 45242

Palette LIFE SCIENCES

Please fill out the following information and submit to Palette, along with the required documentation.

☐ Copy of Invoice ☐ Explanation of Benefits from Payer ☐ Denial Appeal Letter

PROVIDER INFORMATION

Provider First & Last Name:	Provider NPI:
Practice Name (If Applicable):	
Provider/Practice Address:	
Provider/Practice Phone Number:	Provider/Practice Fax Number:
Practice Contact Name & Phone Number (If Applicable):	

REBATE INFORMATION

Date Product was Purchased:	Actual Product Cost:
Invoice Number:	Amount Covered by Payer (for Product Only):

PATIENT INFORMATION

Patient First & Last Name:	Patient DOB:
Patient Address:	
Patient Diagnosis:	

By signing below, Participant agrees and acknowledges the following:

- I am requesting a partial/full rebate pursuant to the terms of Palette's Temporary Rebate Initiative.
- I have submitted appropriate denial and/or payer coverage documentation that confirms the amount paid by the payer to Palette within 30 days of receipt.
- The amount of the rebate Palette will provide is limited to the difference between the invoiced amount or actual product cost and the amount paid by the payer for the product only.
- Participant acknowledges rebate eligibility is limited to the purchase price of the Product only and does not cover any other costs incurred by the Participant.
- I agree not to bill the patient for physician fees related to the Solesta procedure, including all fees for the Participant's time, services, overhead, supplies, and other administrative fees associated with the Solesta procedure.
- I confirm that all active appeals or claims for the Product have been or will be withdrawn from the insurance company.
- I agree to return to the patient, collected deductible and co-payments for the cost of the Product, in part or in full, as appropriate.
- I agree not to attempt to continue to seek reimbursement for the Product from any payer or patient.
- You may be obligated under law to disclose this rebate to federal for private payers. Consult with your reimbursement experts and/or legal counsel for more information.

Provider Signature:	Today's Date: _____ / _____ / _____

Please fax the **SIGNED REQUEST FORM** and the necessary documents to 513-506-7361.