LEUKEMIA & LYMPHOMA SOCIETY®

The Leukemia & Lymphoma Society (LLS) Co-Pay Assistance Program

Claims FAQs

1. **How often do I have to submit a claim to keep my award active?**

   Patients need to submit a claim every 90 days to keep their award active. This can be done by using the LLS Pharmacy Benefit Card (found on your approval letter) or by submitting claims via mail or fax. For a list of covered expenses and instructions on how to submit a claim, please visit our website ***www.LLS.org/copay.***

2. **How do I submit a claim?**

   All claims can either be faxed to the program at 877-267-2932 or mailed to the Co-Pay Program at the address below. If you are registered on the portal, you may also submit claims through your online portal account.

3. **Can I submit bills for previous years?**
   You can submit claims for services received within the 12 months of coverage period. We offer an up to 90 day "look back" period to new and renewal patients. We may be able to reimburse you for services received up to 90 days prior to your approval date.

   **We are unable to pay for services dated prior to your diagnosis date.*
   ***For renewal patients, the "look back" cannot overlap with previous award coverage period. Please contact the program for further assistance.*

4. **What is the LLS Pharmacy Benefit card?**

   The LLS Pharmacy Benefit card is a virtual pharmacy card (information is found on your award letter) that can be used at your local and specialty pharmacies. Provide the pharmacist with your card information, found on your award letter, and your out-of-pocket cost for covered medications will be paid instantly.

5. **How do I use my Pharmacy Benefit card?**

   Provide the pharmacist with your card information, found on your award letter, and your out-of-pocket cost for covered medications will be paid instantly.

6. **I've misplaced my Proof of Expenditure (POE) form. What should I do?**

   If you are unable to locate, or are unable to make copies of the form, you can call 1-877-557-2672 to get a copy. If you have a portal account, you can access and download a copy.

7. **Can I submit labs, scans and test claims to the program if my doctor is still doing more testing to determine my diagnosis subtype or my mutations?**
   All patients approved into the co-pay program must have a confirmed diagnosis by their physician. Any treatment-related labs, scans, tests with dates of service AFTER their date of diagnosis will be covered.

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Additional labs, scans, tests to obtain more information will be covered as long as the dates of service are within your award coverage period.

8. **Where do I find the list of covered labs, scans and tests?**
   For a complete list of covered expenses, please visit www.LLS.org/copay

9. **Can I get my nutritional supplements covered?**
   If your doctor has prescribed a medication or supplement related to your treatment that is not listed as a covered expense, please submit a doctor's note including the name of the drug/supplement and its supporting medical necessity for your treatment plan.

10. **Does the program cover port flushes?**
    Yes.

11. **Does the program cover premiums, co-pays, deductibles for secondary medical insurances?**
    Yes. The program cover premiums, co-pays, deductibles for secondary medical insurances. For example, the program will cover premiums for Medicare supplement policies, if Medicare is your primary insurance.

    The program does NOT cover premiums for hospital indemnity policies or cancer policies. For example, the program will not cover premiums like Aflac.

12. **My doctor's office requires me to prepay for my treatment. How do I submit a claim to get reimbursed?**
    We suggest you call 1-877-557-2672 to speak with an Intake Specialist to walk through the process. In some cases, the patient may need to follow up with the provider and/or the insurance company.

13. **How can I get information about a claim I submitted?**

    You can check the status of a claim by calling the toll free number, 1-877-557-2672, Monday through Friday 8:30AM to 5:00PM ET. If your claim was submitted via the online portal, you can check the status of the claim in your online account.

14. **What do I do if I already forfeited my award because I was unable to submit a claim within 90 days, do I have to reapply to the program to get assistance or to reactivate my award?**

    You may be able to reactivate your award by submitting a new claim. Please note reactivation is not guaranteed and is dependent on available funding. In the case that reactivation is not possible, you will need to wait until your 12 month coverage period has expired to reapply. Claims submitted must be for eligible expenses for dates of service within your award period.

For any additional questions, please call us at 1-877-557-2672. Thank you!