



LILETTA Patient Savings Program® Fax Cover Sheet

Please complete the information below and fax along with the detailed Explanation of Benefits (EOB) from your insurance company to 1-888-683-4991. Please ensure that the EOB includes the Name of the Insurance Company, Date of Service, Product Name/J Code, and Patient Responsibility amount. If unavailable, please provide supporting documentation. Please provide your email address or fax number where a confirmation receipt can be sent.

If you have questions, please call 1-855-706-4508 Monday through Friday 9 AM – 8 PM ET (except holidays) with any questions.

Patient Name: _____ Patient Fax Number: _____

Patient Mailing Address: _____

Patient Telephone Number: _____ Date of Service (Insertion): _____

LILETTA® Card ID: **LIL** _____ Amount Requested: \$ _____

Doctor's Name: _____ Doctor's Telephone Number: _____

Signature of Patient: _____

We respect individual privacy and value the confidence of our customers. The information pertaining to you that we collect will be used in accordance with Allergan's Privacy Statement, which can be found at <https://www.allergan.com/privacy>. Please note that you can view the Allergan California Privacy Policy at www.allergan.com/privacy/ccpa.

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Liletta® 
(levonorgestrel-releasing
intrauterine system) **52 mg**