CYCLE VITA™
Support *for life*

Field Reimbursement Request Form

Please complete the form below to request a visit from a Field Reimbursement Manager (FRM). Your FRM will contact you promptly to discuss your needs and schedule a visit.

PROVIDER INFORMATION
Provider Name:
Practice Name:
Address:
Contact Information: Phone: Email:
Preferred Contact Method: ☐ Phone ☐ Email

REQUEST DETAILS
Product Name:
Reason for visit (select all that apply): ☐ Benefit Investigation ☐ Prior Authorization Support ☐ Appeals Guidance ☐ Pharmacy Triage ☐ Patient/Copay Assistance ☐ Other: _____
Preferred Visit: ☐ In-Person ☐ Virtual
Requested Date/Time: Date: ____ / ____ / ____ Time: ____ : ____ ☐ AM ☐ PM

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PATIENT INFORMATION (OPTIONAL)
The information provided in this section is considered PHI and will be handled in compliance with privacy regulations.
Patient Name:
Date of Birth: _____ /_____ /_____
Case ID:

AUTHORIZATION
By submitting, you consent to a follow-up from an FRM.
Signature:
Date: _____ /_____/ _____

Please submit this form securely to your dedicated Field Reimbursement Manager.

Email: hello@cyclevita.life

Fax: 888-385-8482

For questions, contact us at:

888-360-8482 or

hello@cyclevita.life

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