Renvela®
sevelamer carbonate

pskw®

PATIENT MAIL-IN FORM

To receive reimbursement within 3 weeks for a valid prescription claim, please take the following steps:

1. Go To RenValue.com to download $5 co-pay card if you do not already have one.
2. Mail this form and the original pharmacy receipt to:

   Renvela® RenValue Offer
   PO Box 7017
   Bedminster, NJ 07921

The original pharmacy receipt should include:

1. Patient Name and Address
2. Pharmacy Name, Address, and Phone
3. Prescription #, Fill Date, Drug Name, Strength, NDC #, and Quantity
4. Amount of your out-of-pocket payment

First Name: _____

Last Name: _____

Date of Birth (MM/DD/YYYY): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____)-_____-_____

Group # (on your RenValue card): _____

ID # (on your RenValue card): _____

Are you privately insured? ☐ Yes ☐ No