EXPRESS SCRIPTS®

Prescription Drug Claim Form

Please refer to instructions on reverse side.

STEP 1 CARDHOLDER/PATIENT INFORMATION

(to be completed by patient)

Cardholder ID # DIV

Cardholder's name *(Last)* *(First)* *(MI)*

Address

City State ZIP

Patient information *(Please list information for the patient submitting claims; allow one claim form for each patient.)*

Patient's name *(Last)* *(First)* *(MI)*

Relationship to cardholder? Self ☐ Spouse ☐ Dependent ☐ Gender M ☐ F ☐

Date of birth *(Month/Day/Year)*

STEP 2 CLAIM INFORMATION FROM PHARMACY RECEIPT

(to be completed by patient)

Reason for submission? ☐ Forgot insurance card ☐ Processing error at pharmacy ☐ Out of network pharmacy ☐ Other _____

Is this a compound Rx? Y ☐ N ☐ *(If yes, please attach a compound claim form from the pharmacy.)*

Does the patient reside in an assisted living facility? Y ☐ N ☐ Is this for an allergy serum? Y ☐ N ☐

Is this claim for a diabetic supply? Y ☐ N ☐ Was a discount card used? Y ☐ N ☐

Was this prescription filled in a foreign country? Y ☐ N ☐ Country code Currency used _____

Foreign medication name _____

Foreign amount paid _____

Please include a pharmacy receipt with the following information:

Fill date, Rx number, National Drug Code (NDC), medication name (in English), strength, dosage, quantity, days supply, amount paid, prescriber name, and the prescriber NPI#

STEP 3 OTHER INSURANCE COVERAGE

(to be completed by patient)

Is the patient eligible for primary prescription-drug coverage from another provider? Y ☐ N ☐

If yes, did the patient submit the claim to this other provider? Y ☐ N ☐ *(If yes, please attach the explanation of benefits from the other provider.)*

Did the prior insurance pay in error? Y ☐ N ☐

(Over)

STEP 4 AUTHORIZATION *(to be completed by pharmacist/physician if pharmacy receipts are not submitted)*

Pharmacy name

National Provider (NPI) number

Pharmacist/physician name

Address

City State ZIP

Pharmacist/physician signature _____

Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of your prescription drug plan administrator.

STEP 5 SIGNATURE

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Cardholder's signature _____ Date *(Month/Day/Year)*

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

- **Please print clearly in each box, being careful not to touch the edges of each box.**
- **Please do not highlight the claim form or the prescription receipts.**
- **Please sign the claim form. Unsigned claim forms cannot be processed and will be returned.**
- **Please use a separate claim form for each patient (or family member).**
- **Each submission must include prescription receipts/labels *OR* a patient history printout from your pharmacy, signed by the dispensing pharmacist.**
- **If you have multiple receipts for the same patient, please attach them to this claim form.**
- **Please note that claims missing any of the above information may be returned or payment may be denied**.
- **It is preferable to submit receipts either unattached to this form or taped to a separate piece of paper. Please DO NOT use staples or glue**.
- **If applicable, include Power of Attorney, Executor of Estate, or Death Certificate documentation**.

Questions? Call Express Scripts at the number on the back of your member ID card.

Please mail this claim to:
Express Scripts
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Medicare Part D members please mail to:
Express Scripts
ATTN: Med D Claims
P.O. Box 66752
St. Louis, MO 63166-6752

You may also fax your claim form to:
608.741.5475.
Please use one claim form per fax. Do not combine claims for different members in the same fax submission.