Prescription Drug Reimbursement / Coordination of Benefits Claim Form

An incomplete form may delay your reimbursement.

See the back for instructions and complete all information.

>> Cardholder	Information See your prescription	>>> Claim Receipts			
Group No.			Tape receipts or itemized bills on the back. See back for details.		
Member ID			Check the appropriate box if any receipts or bills are for a:		
Member Name First	Last	t - 🥷 📆	☐ Compound prescription		
			Make sure your pharmacist lists		
Street Address			ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of		
			this form and attach receipts. Claim will be returned if incomplete.		
City		State ZIP	ONE CLAIM FORM PER		
			COMPOUND SUBMISSION		
>> Patient Info	rmation	Medication purchased outside			
Patient Name First	Last	of the United States Please indicate:			
			Country		
Patient Date of Birth	ı (Month/Day/Year) 🔲 🔲 🔲				
Sex	Relationship to Plan Member		Currency used		
☐ Female	☐ 1 Self	☐ 5 Disabled Dependent	Allergy medication		
☐ Male	☐ 2 Spouse	☐ 6 Dependent Parent	Coordination of Benefits		
)	3 Eligible Child	7 Non-spouse Partner	(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method.		
	☐ 4 Dependent Student	☐ 8 Other	See the back for more information.		
>> Pharmacy Ir	ıformation		Is this a coordination of benefits claim? Yes No		
Name of Pharmacy			Another Health Plan paid and you are enclosing		
			a statement that outlines how much you paid		
Street Address			and how much the other carrier paid (1)		
			Card Program (3)		
City		State ZIP	Express Scripts Mail Order (4)		
			Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim		
Telephone (include a	rea code)		or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such		
Is this an on-site nu	rsing home pharmacy? 🔲 Yes 🗆	□ No	claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal		
I hereby certify that the charg	ge(s) shown for the medication(s) prescribed is correct	t and agree to provide Express Scripts or its agents reasonable th applicable law. I further recognize that reimbursement will	or civil penalties, including fines and/or imprisonment or		
	ember and assignment of these benefits to a pharma	cy or any other party is void.	denial of benefits.†		
Χ		NCPDP/NPI Required	Please tape receipts on the back of this page.		
	cist or Representative (Required)				
>> Acknowledgment					
I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. By completing this form, I recognize that reimbursement will be paid directly to me and that					
assignment of these be	enefits to a pharmacy or any other party is	s void.*			
X Cinnatura of Manual		Data			
Signature of Member		Date			

EXPRESS SCRIPTS®

^{*}If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form.

>> Claim Receipts

Please tape your receipts here. Do not staple! If you have additional receipts, tape them on a separate piece of paper

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- · Date prescription filled
- · Name and address of pharmacy
- · Doctor name or ID number
- NDC number (drug number)
- · Name of drug and strength
- · Quantity and day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- · Name and address of pharmacy
- · Doctor name or ID number
- · NDC number (drug number)
- . Name of drug and strength
- · Quantity and day supply
- · Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

COMPOUND PRESCRIPTIONS ONLY

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #		
Date Filled	Day Supply Quantity	
Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost
	Total charge	

>> Instructions Read carefully before completing this form.

- 1. Always present your prescription drug ID card at the participating retail pharmacy.
- Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims under Coordination of Benefits rules:
- 3. You must complete a separate claim form for each pharmacy used and for each patient.
- 4. You must submit claims within 1 year of date of purchase or as required by your plan.
- 5. Be sure your receipts are complete.
 In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
- 6. The plan member should read the acknowledgment carefully, and then sign and date this form.

7. Return the completed form and receipt(s) to: Express Scripts

ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872

8. 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.

Additional Coordination of Benefits Instructions

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided at the top of this page, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

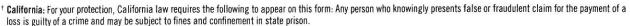
Prescription Drug Programs or HMO Plans

Retail pharmacies

If the primary plan is one in which a copayment or coinsurance is paid at a retail pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

The Express Scripts Pharmacy

If the primary plan is mail order, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.



Pennsylvania: 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.



