Prescription Drug Reimbursement / Coordination of Benefits Claim Form

An incomplete form may delay your reimbursement.
See the back for instructions and complete all information.

EXPRESS SCRIPTS®

Cardholder Information *See your prescription drug ID card.*

Group No.

Member ID

Member Name First Last

Street Address

City State ZIP

Patient Information

Patient Name First Last

Patient Date of Birth (Month/Day/Year) __/__/____

Sex

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) ___-___-____

Is this an on-site nursing home pharmacy? ☐ **Yes** ☐ **No**

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X _____
Signature of Pharmacist or Representative **(Required)**

NCPDP/NPI Required

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**

Make sure your pharmacist lists 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.

ONE CLAIM FORM PER COMPOUND SUBMISSION

☐ **Medication purchased outside of the United States**

Please indicate:

Country _____

Currency used _____

☐ **Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Mail Order (4)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

Please tape receipts on the back of this page.

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 benefits to a pharmacy or any other party is void.**

X _____ _____
Signature of Member Date

*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.

Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.

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.
2. 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 14711
   Lexington, KY 40512-4711
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.

† **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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