Prescription Drug Reimbursement Form

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

EXPRESS SCRIPTS®

Member/Subscriber 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, Middle, 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

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

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

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

☐ **Medicare Part B medication**

☐ **Allergy serum**

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.

Acknowledgment

I certify that the medication(s) described above 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 also certify that the medication received was not for an on-the-job injury or covered under another benefit plan (unless you are seeking Coordination of Benefits under Medicare Part B). *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 1 800 922-1557 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 days' 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 days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For 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		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

Direct Reimbursement Claim Instructions

Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
   - The pharmacy does not accept your Express Scripts prescription drug ID card, or
   - You have not received your Express Scripts prescription drug ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within 16 months from the date of purchase 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 above. 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: Direct Claims
   P.O. Box 2824
   Clinton, IA 52733-2824

* **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.

Visit us online anytime at www.Express-Scripts.com.

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