# **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 drug ID card.	>> 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
Member Name First Last	or bills are for a:
	Compound prescription
	Make sure your pharmacist lists ALL the VALID NDC numbers, cost and
Street Address	quantities for each ingredient on the back of
	this form and attach receipts. Claim will be
City State ZIP	returned if incomplete.  ONE CLAIM FORM PER
	COMPOUND SUBMISSION
>> Patient Information	■ Medication purchased outside
Patient Name First Last	of the United States
	Please indicate:
	Country
Patient Date of Birth (Month/Day/Year)	Currency used
Sex Relationship to Plan Member	Currency used  Allergy medication
Female 1 Self 5 Disabled Dependent	Allergy illeuteation
☐ 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 Information	Is this a coordination of benefits claim?
Name of Pharmacy	Yes No
	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,
Telephone (include area code)	injure, or deceive any insurance company submits a clain or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such
Is this an on-site nursing home pharmacy?	claim may be committing a fraudulent insurance act, which is a crime and may subject such person to crimina
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.	or civil penalties, including fines and/or imprisonment or denial of benefits.†
X NCPDP/NPI Required	Please tape receipts on the back of this page.
Signature of Pharmacist 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 benefits to a pharmacy or any other party is void.\*

J	•	,	,	,	,			
X								
Signature of Member						Date		

<sup>\*</sup>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 Quantit	y
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

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.

**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.





<sup>†</sup> 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.