Prescription Drug Reimbursement Form

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

Member/Subscriber Information See your prescription drug ID card	
Group No.	Tape receipts or itemized bills on
	the back. See back for details.
Member ID	
NA	Check the appropriate box if any receipts or bills are for a:
Member Name (First, Last)	,
Street Address	☐ Compound prescription Make sure your pharmacist lists
June 2017	ALL the VALID NDC numbers, cost
City State Zip	and quantities for each ingredient on
	the back of this form and attach receipts. Claim will be returned
Patient Information	if incomplete.
	ONE CLAIM FORM
Patient Name (First, Last)	PER COMPOUND SUBMISSION
Patient Date of Birth (Month/Day/Year)	
Sex Relationship to Plan Member □ Female □ 1 Self □ 5 Disabled Dependent	☐ Medication purchased outside of
☐ Male ☐ 2 Spouse ☐ 6 Dependent Parent	the United States Please indicate:
☐ 3 Eligible Child ☐ 7 Nonspouse Partner	
☐ 4 Dependent Student ☐ 8 Other	Currency used
Pharmacy Information	Currency used Allergy medication
	☐ Allergy medication
Name of Pharmacy	
	Any person who knowingly and with inter
Street Address	to defraud, injure, or deceive any insuranc company submits a claim or application
	containing any materially false, deceptive,
City State Zip	incomplete, or misleading information pertaining to such claim may be committin
Telephone (include area code)	a fraudulent insurance act, which is a crim
Is this an on-site nursing home pharmacy? □Yes □ No	and may subject such person to criminal or civil penalties, including fines and/or
I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide	imprisonment or denial of benefits.*
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	Please tape receipts on the back.
Signature of Pharmacist or Representative (Required) NABP Number Required	
Acknowledgment	
I certify that the medication(s) described above was received for use by the patient listed	
eligible for prescription drug benefits. I also certify that the medication received was no benefit plan. By completing this form, I recognize that reimbursement will be paid direct	
pharmacy or any other party is void.*	ay to me and that assignment of these benefits to a
V	
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. 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	Days'	
	filled	supply	

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

Direct Reimbursement Claim InstructionsRead 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 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 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 P.O. Box 14711 Lexington, KY 40512

* **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 Express-Scripts.com





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