

Commercial Prescription Drug Claims Form

Please refer to instructions on reverse side.

STEP 1	CARDHOLDER/PATIENT INFORMATION	(to be completed by patient)		
Cardholder ID #				
Cardholder's nai	me (Last) (Firs	St) (MI)		
Address City		State ZIP		
Patient informa	tion (Please list information for the patient submitting claims; allow one clai	im form for each patient.)		
Patient's name ((Firs.	t) (MI)		
Relationship to o	cardholder? Self Spouse Dependent Gender M Conth/Day/Year)	F		
STEP 2 CLAIM INFORMATION FROM PHARMACY RECEIPT (to be completed by patient)				
Reason for submission? Forgot insurance card Processing error at pharmacy Out of network pharmacy Other				
Is this a compound Rx? Y N (If yes, please attach a compound claim form from the pharmacy.)				
Does the patient reside in an assisted living facility? Y N Is this for an allergy serum? Y N N				
Is this claim for a diabetic supply? Y N Was a discount card used? Y N				
Was this prescription filled in a foreign country? Y N Country code Currency used				
Foreign medicat	ion name			
Foreign amount	paid			
Please include a pharmacy receipt with the following information: Fill date, Rx number, National Drug Code (NDC), medication name (in English), strength, dosage, quantity, days supply, amount paid, prescriber name, and the prescriber NPI#				
STEP 3	OTHER INSURANCE COVERAGE (to be co	ompleted by patient)		
Is the patient eligible for primary prescription-drug coverage from another provider? Y N				
If yes, did the patient submit the claim to this other provider? Y N (If yes, please attach the explanation of benefits from the other provider.)				
Did the prior insi	Did the prior insurance pay in error? Y N N			

STEP 4 AUTHORIZATION	(to be completed by pharmacist/physic	ian if pharmacy receipts are not submitted)		
Pharmacy name National Provider (NPI) number Pharmacist/physician name					
Address					
City		State	ZIP		
Pharmacist/physician signature					
Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of your prescription drug plan administrator.					
STEP 5 SIGNATURE					
PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. By signing this form, I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. 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.					
Cardholder's signature		Date (Month/Day/Year)			

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

- Print clearly in each box, being careful not to touch the edges of each box.
- Do not highlight the claim form or the prescription receipts.
- Sign the claim form. Unsigned claim forms cannot be processed and will be returned.
- Note that claims missing information may be returned or payment may be denied.
- If you have multiple receipts for the same patient, include them in the same submission.
- Use a separate claim form for each patient (or family member).
- Each submission must include prescription receipts/labels *OR* a patient history printout from your pharmacy, signed by the dispensing pharmacist.
- It is preferable to submit receipts either unattached to this form or taped to a separate piece of paper. DO NOT use staples or glue.

for different members in the same fax submission.

• If applicable, include Power of Attorney, Executor of Estate, or Death Certificate documentation.

Questions? Call Express Scripts at the number on the back of your member ID card. Medicare Part D members should refer to their plan sponsor for the proper claim form and mailing address.

Mail this claim to: Express Scripts

ATTN: Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872 You may also fax your claim form to: 608.741.5475.

Please use one claim form per fax. Do not combine claims