Prescription Drug Claim Form

A. - Cardholder / Patient Information

Today's Date				
Cardholder's Name (Last, First, MI)	Address	City	State	ZIP

Cardholder ID Number	Plan Name	Why was the insurance or drug card not used for this purchase? Explain below.

Patient's Name (Last, First, MI)	Patient's Date of Birth	Patient's Gender ☐ M ☐ F	Patient's Relationship to Cardholder ☐ Self ☐ Spouse ☐ Child ☐ Other

Is the patient eligible for Medicare, Part D (prescription drug) coverage?
☐ No ☐ Yes

B. Other Insurance Coverage

Is the patient eligible for primary prescription drug coverage from another provider? ☐ No ☐ Yes If *Yes,* please use other insurance card to complete the following fields.	Insured's Name (Last, First, MI)

Other Insurance Company's Name	Member ID	PCN	Other Coverage's Effective Date

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Express Scripts, its agents or representatives.

Signature _____ Date _____

Complete all sections ***ONLY if*** the ***original*** pharmacy prescription receipts are not being submitted with this form. Receipt copies will not be accepted.

C. - Authorization (Completed by pharmacist / physician)

National Provider Indicator (NPI) number	Pharmacy Name

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.

D. - Claim Information (Completed by pharmacist/physician)

1. Is this a compound Rx? **If *Yes*, please attach a Compound Claim form.** ☐ No ☐ Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage

National Drug Code (NDC)	Medication Name (U.S. English)	Charge (U.S. Dollars)	Prescriber Name	Prescriber ID

Was this prescription filled in a foreign country? ☐ No ☐ Yes	Name of Country	Currency	Foreign Medication Name	Foreign Charge

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Express Scripts, Inc., is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

2. Is this a compound Rx? **If *Yes*, please attach a Compound Claim form.** ☐ No ☐ Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/ Dosage

National Drug Code (NDC)	Medication Name (U.S. English)	Charge (U.S. Dollars)	Prescriber Name	Prescriber ID

Was this prescription filled in a foreign country? ☐ No ☐ Yes	Name of Country	Currency	Foreign Medication Name	Foreign Charge

3. Is this a compound Rx? **If *Yes*, please attach a Compound Claim form.** ☐ No ☐ Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/ Dosage

National Drug Code (NDC)	Medication Name (U.S. English)	Charge (U.S. Dollars)	Prescriber Name	Prescriber ID

Was this prescription filled in a foreign country? ☐ No ☐ Yes	Name of Country	Currency	Foreign Medication Name	Foreign Charge

4. Is this a compound Rx? **If *Yes*, please attach a Compound Claim form.** ☐ No ☐ Yes	Fill Date	Rx Number	Quantity	Days Supply	Strength/ Dosage

National Drug Code (NDC)	Medication Name (U.S. English)	Charge (U.S. Dollars)	Prescriber Name	Prescriber ID

Was this prescription filled in a foreign country? ☐ No ☐ Yes	Name of Country	Currency	Foreign Medication Name	Foreign Charge

Insurance Fraud Warning
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate state agency within the department of regulatory agencies.

INSTRUCTIONS

Cardholder:

1. Present your prescription drug card at the pharmacy to avoid having to submit a paper claim for reimbursement. If necessary, use this form for prescription claims that were purchased due to an emergency or at a non-participating pharmacy.
2. Complete all items in the section (A) and (B) for both cardholder and patient.
3. Sign the form in the area provided.
4. Include the ORIGINAL prescription receipt with this form and make copies for your records. Copies of the receipt will not be accepted for reimbursement.
5. **If original pharmacy receipts are being submitted with this form, please go to step 7. If not continue to step 6.**
6. If original pharmacy receipts are NOT submitted with the form, please have your pharmacist complete sections (C) and (D) on page 2.
7. Mail completed form to: **Prescription Drug Plan – PO Box 145433 – Cincinnati, OH 45250-5433**

English: If you have any questions regarding this form, please contact one of our customer service representatives by calling the number on the back of your ID card or in your enrollment booklet.

Tagalog: Kung mayroon kang mga katanungan may kinalaman sa form na ito, mangyaring makipag-ugnayan sa isa sa aming mga customer service representative sa pamamagitan ng pagtawag sa numero na nasa likod ng iyong ID card o sa iyong booklet sa pagpapatala.

Vietnamese Nếu quý vị có bất kỳ câu hỏi gì liên quan đến mẫu đơn này, xin vui lòng liên hệ với một trong những đại diện dịch vụ khách hàng của chúng tôi bằng cách gọi số điện thoại ở sau thẻ ID của quý vị hay ở cuốn sổ tuyển dụng.

Spanish: Si tiene alguna pregunta respecto a este formulario, por favor, comuníquese con nuestros representantes de servicio al cliente llamando al número que se encuentra al reverso de su tarjeta de identificación o en su folleto de inscripción.

Korean: 본양식에관한문의사항이있으시면귀하의ID카드뒷면또는등
록책자에있는전화번로
로전화하셔서고객서비스상담원에게문의하여주십시오.

Chinese: 如果你对此表格持有任何疑问，请致电您所持会员卡背后的或者
是注册簿上的电话号码，以联系我
们的客服代表。

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