Prescription Drug Claim Form

A. - Cardholder / Patient Information

Today's Date	

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

Cardholder ID Numbe	Plan Name	Why was the insurance or drug card not used for this purchase? Explain belo

Patient's Name (Last, First, MI	Patient's Date of Birth	Patient's Gende	Patient's Relationship to Cardholde
		☐ M ☐ F	☐ 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 provide	Insured's Name (Last, First, MI
☐ No ☐ Yes If *yes* , please use other insurance card to complete the following field	

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) numbe	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

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

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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: 본 양식에 관한 문의사항이 있으시면 귀하의 ID카드 뒷면 또는 등록 책자에 있는 전화번호로 로 전화하셔서 고객 서비스 상담원에게 문의하여 주십시오.

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。

Japanese: 日本語：この書類についてご不明な点は、お客様のIDカードの裏面または保険加入用冊子に記載された電話番号にお電話いただいた上、お客様サービス担当係にお問い合わせください。

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