Prescription Drug Reimbursement Form

EXPRESS SCRIPTS®

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

Member/Subscriber Information See your Member ID card.

Group Number

Member ID

Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient's Name (First, Last)

Patient's Date of Birth (MM/DD/YY) / /

Sex

☐ Female
☐ Male

Relation to Plan Member

☐ 1. Self
☐ 2. Spouse
☐ 3. Eligible Child
☐ 4. Dependent Student
☐ 5. Disabled Dependent
☐ 6. Dependent Parent
☐ 7. Other
☐ 8. Non-Spouse Partner

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? ☐ Yes ☐ No

I hereby certify that the charge(s) shown for the medications prescribed is (are) 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 otherwise is void.

X

Signature of pharmacist or representative (Required) NABP Number Required

Claim Receipts

Tape claim receipts or itemized bills on the back. Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

☐ is a compound prescription. If so, make sure your pharmacist lists all the ingredients and quantities on the receipt.

☐ was purchased outside the U.S.A If so, please indicate:

Country _____

Currency used _____

☐ is for treatment of an allergy.

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (and patient, if not myself) am/are eligible for drug benefits. I also certify that the medication received was not for a on-the-job injury or covered under another benefit plan. I authorize the release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the ber plan programs. This information may also be used for other reporting and analysis purposes without identificatio me or my family members. I further authorize the use of my Social Security Number for identification purpose: recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or other party is void.

X

Signature of Member

C5001 6-9

Claim Receipts

Please tape your receipts here. Do not staple!

Tape receipt for Rx 1 here

Authorization code for Rx 1

Tape receipt for Rx 2 here

Authorization code for Rx 2

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 Rx 3 here

Authorization code for Rx 3

Tape receipt for Rx 4 here

Authorization code for Rx 4

Direct Reimbursement Claim Instructions

Read carefully before completing this form

1. You must purchase your prescription from an Express Scripts participating pharmacy to receive an Express Scripts reimbursement for your prescriptions. Your plan sponsor will provide a list of participating pharmacies in your area. If you choose to use a non-participating pharmacy, you will lose the advantage of the Express Scripts discounted price.
2. You must complete a separate claim form for each pharmacy used and for each patient.
3. You must submit claims within one year of date of purchase or as required by your plan.
4. 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 it is not itemized on your claim or bill.
5. The plan member should read the Acknowledgement carefully, then sign and date this form.
6. Return the completed form and receipts t

Express Scripts
PO Box 14711
Lexington, Kentucky 40512