

Prescription Drug Reimbursement Form

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



EXPRESS SCRIPTS®

Member/Subscriber Information *See your prescription drug ID card.*

Group No.
Member ID

Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex	Relationship to Plan Member	
<input type="checkbox"/> Female	<input type="checkbox"/> 1 Self	<input type="checkbox"/> 5 Disabled Dependent
<input type="checkbox"/> Male	<input type="checkbox"/> 2 Spouse	<input type="checkbox"/> 6 Dependent Parent
	<input type="checkbox"/> 3 Eligible Child	<input type="checkbox"/> 7 Nonspouse Partner
	<input type="checkbox"/> 4 Dependent Student	<input type="checkbox"/> 8 Other

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 medication(s) prescribed is 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 any other party is void.

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 above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.*

Signature of Member

_____ Date

Claim Receipts

Tape receipts or itemized bills on the back.

See back for details.

Check the appropriate box if any receipts or bills are for a:

- Compound prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

**ONE CLAIM FORM
PER COMPOUND SUBMISSION**

- Medication purchased outside of the United States**
Please indicate:

Country _____
Currency used _____

- Allergy medication**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.*

Please tape receipts on the back.

*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.

