Prescription Drug Claim Form- Medicare Part D

You are not required to use this form. You may submit other documentation that provides all of the requested information.

A. Cardholder - Patient Information			**Today's Date:**		
Cardholder's Name (Last, First, MI)		Address	City	State	Zip Code
Cardholder ID Number	Plan Name		Patient's Date of Birth / /		Gender □ M □ F
Why was the prescription drug card NOT used for this purchase? Please explain below:					

B. Other Insurance Coverage			
Is patient eligible for primary prescription drug coverage from another provider? □ Yes □ No **If yes, please use that insurance card to complete the fields below. Please also include a copy of the Explanation of Benefits from that provider when submitting this drug claim form.**			
Insured's Name (Last, First, MI)			
Other Insurance Company's Name	Member ID	PCN #	Coverage 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, Inc, its agents, or representatives.

Signature: _____ Date: _____

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Information for your Pharmacist/Physician: By completing Sections C and D, you certify the information correctly represents the amount paid by the member for the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

If more than three (3) prescriptions are being submitted, please complete additional claim form(s).

C. Claim(s) Information					
1. Is this a compound Rx? □ Yes □ No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? □ Yes □ No	Prescriber Fax Number:				
2. Is this a compound Rx? □ Yes □ No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? □ Yes □ No	Prescriber Fax Number:				
3. Is this a compound Rx? □ Yes □ No	Fill Date / /	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? □ Yes □ No	Prescriber Fax Number:				

Compounds
Even if you have itemized receipts, the following must be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications.

NDC Number	Ingredient	Quantity	Cost
Compounding Fee			

D. Authorization				
National Provider Indicator (NPI) Number	Pharmacy Name			
Pharmacist/Physician Name	Pharmacy Address	City	State	Zip Code
Pharmacist/Physician Signature:				

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St. Louis, MO 63166-6752

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Please return this claim form to:
Express Scripts, Inc
P.O. Box 66752
St. Louis, MO 63166-6752
ATTN: MED-D Accounts

Instructions for using this form:

1. Present your prescription drug card at the pharmacy to avoid having to submit this drug claim form for reimbursement.
2. If necessary, use this form for prescription claims that were purchased without presenting your card due to an emergency or at a non-participating pharmacy. For consideration of payment, you *must* send Express Scripts all of the requested information for each claim at the address below. Express Scripts will process your claim(s) within 14 days and notify you of the determination. Express Scripts will contact you should you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.
3. **Complete all items in sections (A) and (B)**. Sign the form in the area provided. Enclose original receipts with this form. Be sure your itemized receipts include the following:
   1) Pharmacy Name
   2) Pharmacy NABP Number
   3) Prescription Number
   4) Date of Purchase
   5) Medicine Name
   6) Strength
   7) Quantity Dispensed
   8) Physician ID Number
   9) Total Amount Charged For Each Prescription

   Please make copies for your records.
4. **If your claim is for a compound drug, please have your pharmacist or physician complete sections (C) and (D) of this form.**
5. **If you are not able to submit original pharmacy receipts, please have your pharmacist or physician complete sections (C) and (D) of this form**.
6. Items not covered under your prescription benefit plan should not be submitted for reimbursement including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan.
7. Mail completed form to:
   Express Scripts, Inc
   P.O. Box 66752
   St. Louis, MO 63166-6752
   ATTN: MED-D Account

   Questions? If you have any questions please call the phone number on your ID card.