Prescription Drug Claim Form/Coordination of Benefits
See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

MEDICAL MUTUAL® | EXPRESS SCRIPTS®

Member/Subscriber Information See your member ID card.

Group No. MMODRUG

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

☐ Female
☐ Male

Relation to Plan Member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Non-spouse Partner
☐ 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 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 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 11-digit NDC numbers, ingredients, cost and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**

Please indicate:

Country _____

Currency used _____

☐ **Allergy medication**

Coordination of Benefits

(Another health plan has paid a portion) Mark the appropriate box for your primary coverage method. See the back for more information.

☐ 1 Another health plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid
☐ 3 Prescription drug card program
☐ 4 Express Scripts Pharmacy℠ home delivery service

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.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (and the patient, if not myself) am/are eligible for drug benefits. I also certify that the medication received was not for an 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 benefit plan programs. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I further authorize the use of my Social Security number for identification purposes. 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.

X

Signature of Member Date

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 800,922.1557 for assistance.

15EME33625 Z3612-RXX R02-14 C3004 12-15

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

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 prescription 2 here.

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

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #:		Date filled:		Days' supply:	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

When To Use This Form

- Use this form to submit claims under Coordination of Benefits rules.
- You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
- You must submit claims within one year of date of purchase or as required by your plan.

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. Once the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided above, and attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Prescription Drug Programs or HMO Plans

Retail pharmacies: If the primary plan is one in which a copayment or coinsurance is paid at the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the EOB.

Express Scripts home delivery service: If the primary plan is the Express Scripts Pharmacy, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the mail-order pharmacy or the statement of benefits you receive from the mail-order pharmacy.

* **California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Instructions

Read carefully before completing this form

1. **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 your claim or bill is not itemized.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Return the completed form and receipt(s) to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Visit us online anytime at Express-Scripts.com.