

Prescription Drug Claim Form/Coordination of Benefits

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



Member/Subscriber Information See your member ID card.

Group No. **M M O E X C H**
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 *Relation 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 Non-spouse 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 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 PharmacySM 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.

