# **Prescription Drug Reimbursement / Coordination of Benefits Claim Form**

Did you know that you can now submit your prescription claims to us electronically? Login to My Health Plan at Medmutual.com/Rx and click Sign on to Express Scripts. Then select Benefits → Forms → Start A Claim



>> Cardholder	<b>Information</b> See your prescription drug	g ID card.	>> Claim Receipts
Group No. M	MODRUG		Tape receipts or itemized bills on the back.  See back for details.
Member ID			Check the appropriate box if any receipts or bills are for a:
Member Name Firs	st Last		Compound prescription
			Make sure your pharmacist lists ALL the VALID NDC numbers, cost and
Street Address			quantities for each ingredient on the back of
			this form and attach receipts. Claim will be
City		State ZIP	returned if incomplete.  ONE CLAIM FORM PER
			COMPOUND SUBMISSION
>> Patient Info	ormation	■ Medication purchased outside	
Patient Name First	Last		of the United States
			Please indicate:
Patient Date of Ri	th (Month/Day/Year)	Country	
Sex	Relationship to Plan Member		Currency used
Female	☐ 1 Self	5 Disabled Dependent	☐ Allergy medication
		•	Occurrence of Demostra
☐ Male	2 Spouse	6 Dependent Parent	Coordination of Benefits (Another Health Plan has paid a portion.) Mark the
	3 Eligible Child	7 Non-spouse Partner	appropriate box for your primary coverage method.
	☐ 4 Dependent Student ☐	8 Other	See the back for more information.  Is this a coordination of benefits claim?
>> Pharmacy			Yes No
Name of Pharmac			Another Health Plan paid and you are enclosing
			a statement that outlines how much you paid
Street Address			and how much the other carrier paid (1)
			Card Program (3)
City		State ZIP	Express Scripts Mail Order (4)
			Any person who knowingly and with intent to defraud,
Telephone (include area code)			injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such
Is this an on-site	nursing home pharmacy? 🔲 Yes 🔲 No	claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal	
I hereby certify that the clacess to records related to	or civil penalties, including fines and/or imprisonment or denial of benefits.†		
	n member and assignment of these benefits to a pharmacy or ar	ny other party is void.	
<u>X</u>		NCPDP/NPI Required	Please tape receipts on the back of this page.
	nacist or Representative (Required)		
>> Acknowled	-		
benefits plan. I cer		for an on-the-job injury. By completing this t	patient, if not myself) am eligible for prescription form, I recognize that reimbursement will be paid
X	5		
Signature of Memb	per [	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.

### >> 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 day 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 day supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

#### **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/	Day Supply Quantit	у			
Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost			
	Total charge				

#### >> Instructions Read carefully before completing this form.

- 1. Always present your prescription drug ID card at the participating retail pharmacy.
- 2. Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims under Coordination of Benefits rules:
- 3. You must complete a separate claim form for each pharmacy used and for each patient.
- 4. You must submit claims within 1 year of date of purchase or as required by your plan.
- 5. Be sure your receipts are complete.

In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.

6. The plan member should read the acknowledgment carefully, and then sign and date this form.

7. **Return the completed form and receipt(s)** to: Express Scripts

ATTN: Commercial Claims P.O. Box. 14711

Lexington, KY 40512-4711

8. You may also fax your claim form to: 608,741,5475.

Please use one claim form per fax. Do not combine claims for different members in the same fax submission.

# Additional Coordination of Benefits Instructions 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 at the top of this page, 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 a retail 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® Pharmacy If the

primary plan is home delivery, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the home delivery pharmacy or the statement of benefits you receive from the home delivery pharmacy.

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.



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<sup>†</sup> 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.