C:

EXPRESS SCRIPTS PRESCRIPTION DRUG CLAIM FORM

SECTION A - SUBSCRIBER INFORMATION

Subscriber's Name (last, first, MI)	Subscriber ID Number

Address Street_____

City/State_____ Zip Code_____

Check if new address

Telephone

Home ( ) Work ( )

Employer	Insurance Carrier	Group Number

I Certify that all information provided is correct and that the prescription(s) submitted are for myself or members of my family who are eligible. The patient(s) listed below has(have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor.

_____ _____

Subscriber's Signature Date

SECTION B - PATIENT INFORMATION. Complete this section for each eligible family member who received medication for which you are submitting claims at this time.

	Patient's Name (last, first, MI)	Relationship to Subscriber	Gender	Date of Birth	No. of Prescriptions for Patient	Total $ Amount for Patient
1		Self Dependent Spouse Other	Male Female		_____	$_____
2		Self Dependent Spouse Other	Male Female		_____	$_____
3		Self Dependent Spouse Other	Male Female		_____	$_____
4		Self Dependent Spouse Other	Male Female		_____	$_____

TOTALS FOR ALL PRESCRIPTIONS

	$_____

SECTION C - PRESCRIPTION INFORMATION: IMPORTANT: Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy. Claims received missing any of the following information may be returned or payment may be denied.

- Pharmacy Name/Address
- Date Filled
- Drug Name and Strength
- Rx Number
- Quantity
- Price

Note: Altered receipts require pharmacist signature.

SECTION D - OTHER COVERAGE INFORMATION (Specific coordination of benefits form available upon request.)

- Are any family members eligible for additional prescription drug benefits? Yes No
- Name of other insurance carrier/administrator_____
- Policy Holder's Name_____
- Have these claims been processed by your other insurance? Yes No

SECTION E - REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

_____

_____

_____

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND FILL OUT REVERSE SIDE OF THIS FORM.

SECTION A. Subscriber Information (The Subscriber is the insured member whose employer provides this benefit.)

1. Print Subscriber's name (last, first, middle initial)
2. Print Subscriber's ID number (found on prescription drug or Health Insurance card)
3. Print Subscriber's mailing address and phone numbers
4. Indicate Subscriber's employer, insurance carrier and group number (refer to drug card)
5. IMPORTANT: CLAIM FORM MUST BE SIGNED. (UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED)

SECTION B. Patient Information (Complete this section for each family member who has received medication.)

1. Print Patient's name
2. Identify relationship to subscriber, gender, date of birth, number of prescriptions, and total dollar amount for each patient
3. Total the number of prescriptions and total dollar amount for all patients for which claims are being submitted for processing at this time

SECTION C. Prescription Information Submit either prescription receipts/labels with this claim form or a patient history print-out from your pharmacy. It is preferable to have them unattached. Please don't staple, tape or glue. Claims received missing any of the following information may be returned or payment may be denied.

- Pharmacy name and address
- Drug name and strength
- Date filled
- Rx Number
- Quantity
- Price

Note: Altered receipts require pharmacist signature.

SECTION D. Other Coverage Information

1. Indicate if other family members are covered under another drug plan
2. Print name of other insurance carrier/administrator for that plan
3. Print name of family member who holds other policy
4. Indicate if the claims enclosed have been processed by other insurance

SECTION E. Reason for claim submission or special notes

This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-800-451-6245

Please return this claim to: Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166-6773
ATTN: Claims Department