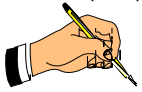


# EXPRESS SCRIPTS PRESCRIPTION DRUG CLAIM FORM

## SECTION A - SUBSCRIBER INFORMATION

Subscriber's Name (last, first, MI)		Subscriber ID Number	
Address Street _____			
City/State _____			Zip Code _____
Check if new address <input type="checkbox"/>			
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
<b>1</b>		Self    Dependent Spouse    Other	Male Female		_____	\$ _____
<b>2</b>		Self    Dependent Spouse    Other	Male Female		_____	\$ _____
<b>3</b>		Self    Dependent Spouse    Other	Male Female		_____	\$ _____
<b>4</b>		Self    Dependent Spouse    Other	Male Female		_____	\$ _____



**TOTALS FOR ALL PRESCRIPTIONS**

	\$ _____
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**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**