EXPRESS SCRIPTS®

PRESCRIPTION DRUG CLAIM FORM MEDICARE PART D

Patient Name (Last, First, MI)	Date of Birth	Gender M F	Patient ID Number

☐ Check if new address

Street_____

City/State_____ Zip Code_____ Daytime Telephone (___)_____

<Plan Name (Plan Type)>	Group Number

♦ Is Medicare Part D the patient's primary coverage? ☐ yes ☐ no

♦ Does the patient have primary coverage under another plan, with Medicare considered secondary?
☐ yes* ☐ no **If yes, please attach an explanation of benefits from your primary carrier.*

PRESCRIPTION INFORMATION

➔ **IMPORTANT**← **All prescription claims must have prescription receipts/labels which include:**

◆ Pharmacy Name/Address	◆ Drug Name, Strength and NDC	◆ Days Supply	◆ Script Number
◆ Patient's Name	◆ Date Filled	◆ Price	◆ Quantity

Please note: The above claim detail information is necessary in order to process your claim request.

◆ **Please tape receipts to separate piece of paper.**

Number of receipts attached: _____

◆ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
(With the exception of diabetic supplies)

◊ Is claim for **DIABETIC SUPPLY**? ☐ yes ☐ no. If **Yes**, please ask your pharmacist which supplies are covered under your Part-D plan. Please ensure receipts include:

Pharmacy Name/Address • Date Filled • Type of Insulin and/or Type of supply
• Quantity •Days Supply • Price •Patient's Name.

Cash register receipts are acceptable but
Pharmacist Signature is required if any information is handwritten.

◊ Is this claim for **allergy serum or vaccination**? ☐ yes ☐ no
If yes, please supply type or additional information: _____

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc., the company chosen by my Plan Sponsor to manage my pharmacy benefit, and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person who 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.

Patient's Signature and Date _____ _____

EXPRESS SCRIPTS®

P.O. Box 66752
St. Louis, MO 63166-6752

Mailing Address Block
Do Not Use

Please return this claim to:
Express Scripts, Inc
P.O. Box 66752
St. Louis, MO 63166-6752
ATTN: MED-D Accounts

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Patient Information

The Patient is the insured member.

1. Print Patient's name (last, first, middle initial).
2. Print Patient's date of birth.
3. Circle the correct letter to indicate if Patient is male or female.
4. Print Patient's ID number (found on prescription drug or health insurance card).
5. Print mailing address and daytime telephone number. Please check box if this is a new address.
6. Indicate health plan name and group number (refer to prescription drug or health insurance card) under which patient is covered.
7. Indicate if Medicare Part D is Patient's primary insurance.
8. Indicate if Patient has primary coverage under another plan. If Patient has primary coverage under another plan, Patient must submit claims with a copy of the explanation of benefits from the primary carrier.

Prescription Information

1. Indicate number of receipts submitted for reimbursement consideration.

In order to be processed, you will need to obtain prescription receipts or a patient history printout from your pharmacy that includes the following prescription detail:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Quantity
- Days Supply
- Price
- Patient's name
- Rx Number

Please note: It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple.

2. Indicate if claim is for diabetic supply. If diabetic supply, please provide drug detail. Please note, only some diabetic supplies are covered under your Medicare Part D plan. Please seek assistance from your pharmacist for further guidance.
3. Indicate if claim is for allergy serum or vaccination and if flagged as yes, please provide drug detail.

Questions? If you have any questions please call the phone number on the back of your ID card.