

# Prescription Drug Reimbursement / Coordination of Benefits Claim Form

Did you know that you can now submit your prescription claims to us electronically?

Login to [express-scripts.com](http://express-scripts.com) and select Benefits → Forms & Cards



EXPRESS SCRIPTS®

## »» Cardholder Information *See your prescription drug ID card.*

Group No.

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  Relationship 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 medication(s) prescribed is 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 any other party is void.

**X** \_\_\_\_\_  
Signature of Pharmacist or Representative (Required)

NCPDP/NPI Required

## »» Acknowledgment

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. *By completing this form, 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.

## »» 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 NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

**ONE CLAIM FORM PER COMPOUND SUBMISSION**

**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.

Is this a coordination of benefits claim?

Yes  No

Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

Card Program (3)

Express Scripts Mail Order (4)

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 of this page.**

## »» 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    Quantity

### Valid 11-digit Ingredient NDC

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Metric Quantity

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Ingredient Cost

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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.

#### The Express Scripts Pharmacy

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

† **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.

**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.



### Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

### Language Assistance

- ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).
  - 注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。
  - CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).
  - 주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.
  - ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).
  - PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).
  - УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).
  - ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។
  - 注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。
  - ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።
  - XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).
  - ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).
  - ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।
  - ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).
  - ໂປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສິ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).
  - ATANSYON:** Si w pale Kreyòl Ayisyen, gen sévis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).
  - ATTENTION:** Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).
  - UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).
  - ATENÇÃO:** Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).
  - ATTENZIONE:** In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).
- توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.