


Member Name (Last, First, MI)		
Member ID Number	Date of Birth	Gender M F
<input type="checkbox"/> Check if new address Street _____ City/State _____ Zip Code _____ Daytime Telephone (_) _____		
Prescription Drug Plan Name		Group Number
♦ Is Medicare Part D the member's primary coverage? <input type="checkbox"/> yes <input type="checkbox"/> no ♦ Does the member have primary coverage under another plan, with Medicare considered secondary? <input type="checkbox"/> yes* <input type="checkbox"/> no *If yes, please attach an explanation of benefits from your primary carrier.		

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 RxBLUE to manage my pharmacy benefit, and RxBLUE. 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.

 **Member's Signature and Date** _____

PRESCRIPTION INFORMATION


Number of receipts attached:

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

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

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

- ♦ **Please tape receipts to separate piece of paper.**
- ♦ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
(With the exception of diabetic supplies)

	♦ Is claim for DIABETIC SUPPLY ? <input type="checkbox"/> yes <input type="checkbox"/> 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 <u>but</u> Pharmacist Signature is required if any information is handwritten. ♦ Is this claim for allergy serum or vaccination ? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, please supply type or additional information: _____
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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.

Cardholder/Patient Information

The Member is the insured. Please complete a separate claim form for each member.

1. Print Member's name (last, first, middle initial).
2. Print Member's Identification Number
3. Print Member's date of birth.
4. Circle the correct letter to indicate if Member is male or female.
5. Print mailing address and daytime telephone number. Please check box if this is a new address.
5. Indicate name of Prescription Drug Plan
6. Indicate if Medicare Part D is Member's primary insurance
7. Indicate if Member has primary coverage under another plan. If Member has primary coverage under another plan, Member must submit claims with a copy of the explanation of benefits from the primary carrier.
8. **CLAIM FORM MUST BE SIGNED.** Unsigned claim forms cannot be processed and will be returned.

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
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

Please note:

- * It is preferable to have receipts unattached or taped to a separate piece of paper. *Please* DO NOT staple or glue.
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? Call Express Scripts' Customer Service Department at 1-800-899-2130

