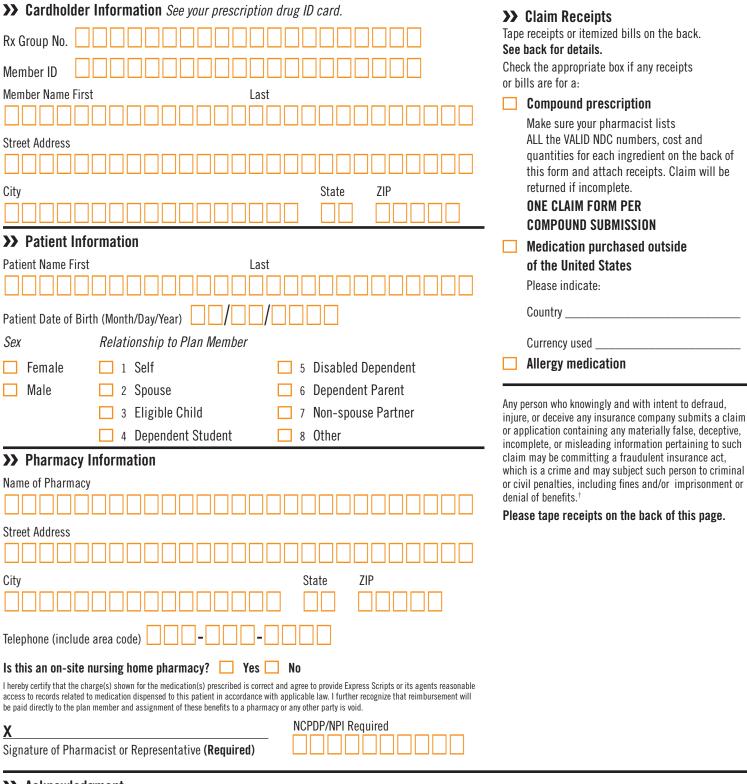
Prescription Drug Reimbursement Form

An incomplete form may delay your reimbursement.

See the back for instructions and complete all information.



EXPRESS SCRIPTS

>> 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.

>> 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:

Total charge

- 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. Day Supply Quantity • For each NDC number, indicate the **Metric Quantity** "metric quantity" expressed in the Valid 11-digit Ingredient NDC **Ingredient Cost** 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.

>> 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.
- 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.

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.



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[†] 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.