



Cardholder's Name (last, first, MI)	Date Of Birth	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Cardholder ID Number
<input type="checkbox"/> Check if new address Address Street _____ City/State _____ Zip Code _____ Daytime Telephone _____			
Employer	Insurance Carrier	Group Number	

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me 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.



Cardholder's Signature

Date

Patient Information (please list information for each patient submitting claims)

1	Patient's Name	Relationship to Cardholder? (check one) Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	How many prescriptions attached?
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor):		

2	Patient's Name	Relationship to Cardholder? (check one) Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	How many prescriptions attached?
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor):		

3	Patient's Name	Relationship to Cardholder? (check one) Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	How many prescriptions attached?
Pharmacy Name and Address:			Physician Name (name of prescribing Doctor):		

Is claim for Diabetic Supply? yes no. If Yes, Patient's name _____
 Type of supply (lancets, syringe, etc.) _____ Quantity _____ Days Supply _____
 Does the patient reside in an assisted living facility? yes no Is this claim for allergy serum? yes no
 Does the patient have primary prescription drug coverage through another insurance carrier? yes no
 Did the patient submit this claim to the other carrier? yes no *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

→ IMPORTANT ← All prescription claims must have prescriptions receipts/labels which include:
 • Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply • Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

Please tape receipts to separate piece of paper

Patient history print outs from the pharmacy are also acceptable but **MUST** be signed by the Pharmacist.

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

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

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

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card).

IMPORTANT: CLAIM FORM MUST BE SIGNED.

UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

Patient Information (Complete a section for each family member who is submitting prescriptions.)

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:

Prescription receipts/labels or a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

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

(Please note that Claims received missing any of the above information may be returned or payment may be denied.)

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

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 66583
St. Louis, MO 63166-6583
ATTN: Std. Accounts