Prescription Drug Reimbursement / Coordination of Benefits Claim Form

Did you know that you can now submit your prescription claims to us electronically?
Log in to express-scripts.com and select Benefits > Forms & Cards

EVERNORTH HEALTH SERVICES

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

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 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

NCPDP/NPI Required

If this reimbursement is for a Covid-19 home test kit, no pharmacist signature or NPI is required.

Claim Receipts

Tape receipts or itemized bills on the back.

Check the appropriate box if applicable:

☐ **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.

☐ **Medication Purchased Outside of the United States**

Country _____

Currency used _____

☐ **Allergy Medication**

☐ **Covid Test Kit**

Kit Name _____

Number of Kits _____

Purchase Date _____

This test was purchased by the customer for personal use or the use of a covered plan member and was not purchased for employment purposes.

This test will not be reimbursed by another source nor placed for resale.

☐ **Another Insurance Carrier Paid for This Claim in Error.**

Make sure a detailed collection letter is provided with your receipt.

Coordination of Benefits

Mark the appropriate box for your primary coverage method.
Did another insurance pay for all/part of this claim?

☐ Yes ☐ No

Is an Explanation of Benefits included?

☐ Yes ☐ No

Is this a discount card claim?

☐ Yes ☐ No

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.

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

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	Metric Quantity	Ingredient Cost
☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐☐
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☐☐☐☐☐☐☐☐☐☐☐	☐☐☐☐☐☐☐	☐☐☐☐☐☐☐☐
	Total charge	☐☐☐☐☐☐☐☐

Read instructions 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 claims form for each pharmacy used and for each patient.**
4. You must submit 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 52017
   Phoenix, AZ 85072-2017
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

Did another insurance pay for this claim?
You must first submit the claim to the primary insurance. If the primary plan is one in which a copayment or coinsurance is paid at a retail pharmacy, complete the form, and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy.

Is an Explanation of Benefits included?
Some plans require an explanation of benefits from your primary insurance. Once the statement from the primary plan is received from the primary carrier, attach the statement from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan. This does not replace the required receipt from the pharmacy.

Is this a discount card claim?
Prescription claims are filled at a retail pharmacy using a rebate, coupon card, savings card, pharmacy discount plan, or GoodRx, etc. instead of using your prescription plan at the pharmacy. Discounts applied by an Express Scripts discount plan are not eligible for reimbursement.

Prescription Drug Program 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.

Express Scripts® Pharmacy
If the primary plan is home delivery, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid to the home delivery pharmacy or the statement of benefits you receive from the home delivery pharmacy.

WARNING: For your protection, state laws, including in Arizona, California, Maryland and Oklahoma, require the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, potentially including 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.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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