EXPRESS SCRIPTS®
Charting the Future of Pharmacy

Express Scripts-BES
Mail Route # BL0470
PO Box 390873
Bloomington, MN 55439-0873
Member Services Phone Number 800-447-9638

Member Reimbursement Claim Form

IMPORTANT INSTRUCTIONS

When should you use this form?

1) Between the effective date of the prescription program and receipt of your ID card.
2) If you are unable to use an In-Network pharmacy. (*Note:* **Your benefit may not allow the use of an Out-of-Network pharmacy.)**
3) If you are asked to pay cash for your prescription at a participating pharmacy.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each participant Complete all information requested under Part A.
- Complete Part B using the information on the packaging of your prescription or receipt, or ask your pharmacist for assistance.
- Tape receipts to 81/2 by 11 sheet of paper and attach to form.
- Review, sign, and mail completed form with pharmacy receipt(s) to the address at the top of this form. *Note:* **PHARMACY RECEIPT(S) ARE REQUIRED** (legible copies are acceptable) **[Cash register receipts are not accepted.]**

Address Information

_____
Name

_____
Mailing Address

_____
City, State, Zip Code

_____
Telephone Number#

Patient Information

Does this patient reside in a nursing home? ❑ **Yes** ❑ **No**
Is this claim for allergy serum? ❑ **Yes** ❑ **No**
Did the patient use a network pharmacy? ❑ **Yes** ❑ **No**
If no, please give a reason for using an out-of-network pharmacy:
❑ Drug not available at network pharmacy
❑ Prescription needed while on vacation
❑ Emergency
❑ Other_____

REQUIRED INFORMATION

Part A

Pharmacy/Prescriber/ Participant Information

Pharmacy NCPDP # ___ ___ ___ ___ ___ ___ ___ **Pharmacy Name** _____
(ask the pharmacist)

Prescriber DEA # ___ ___ ___ ___ ___ ___ ___ ___ ___ **Prescriber Name** _____
(ask your doctor)

Participant ID # _____ **Patient Name** _____
(refer to the front of your ID card)

Date of Birth_____/_____/_____ **Gender M** ❑ **F** ❑ **Relationship** ❑ **Subscriber** ❑ **Spouse** ❑ **Dependent** ❑ **Other**

Part B

Prescription Information--Contact your pharmacist if you need assistance

Date Dispensed	Prescription Number (RX#)	National Drug Code (NDC# 11 Digits)	Quantity (QTY)	Days Supply (DS)	Amount Paid

Was this medication covered under any other group insurance plan? ☐ **Yes** ☐ **No** **If Yes, give name of insurance company and other employer include pharmacy receipts along with explanation of benefits or pharmacy patient profile.**

_____

AUTHORIZATION: I certify that the above statements are correct and hereby authorize any physician, hospital, employer, union, insurance company, pharmacist, HMO or prepayment organization to supply the Plan Administrator and its agents any information required in connection with this claim. A photocopy of this authorization shall be as valid as the original.

Participant Signature:_____ **Date:**_____

(Processing Center Use ONLY) ☐ **Claim Form Returned**

PLEASE PROVIDE HIGHLIGHTED INFORMATION AND RESUBMIT.

☐ Claim Form Required ☐ Send to previous processor, claim dates are prior to effective date with Express Scripts/DPS. ☐ Pharmacy Receipt(s) ☐ Pharmacy NCPDP# ☐ Pharmacy Name ☐ Dr. DEA# ☐ Dr. Name ☐ Participant ID Number ☐ Participant Name ☐ DOB, Gender, Rel. Code ☐ Date Dispensed ☐ Prescription Number(RX) ☐ National Drug Code(NDC) ☐ Quantity(QTY) ☐ Days Supply(DS) ☐ Amount Paid ☐ Explanation of Benefits or Pharmacy Patient Profile- Part B you have indicated that you have primary coverage through another carrier. ☐ Coordination of Benefits(COB) is not an option under your benefit. ☐ Signature ☐ Participant not in system, contact your health plan or employer. ☐ The NDC# for the most expensive legend ingredient is required for compound medications. ☐ Submit claim(s) to your major medical insurance for processing. ☐ Other_____