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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
- uantity and day supply
- Prescription number (Rx number)
- DA (Dispense As ritten)
- 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
- uantity and day supply
- Prescription number (Rx number)
- DA (Dispense As ritten)
- Amount paid

COMPOUND PRESCRIPTIONS ONLY

List the ALID 11-digit NDC number for EAC 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 T TAL charge (dollar amount) paid by the patient.

Receipt(s) must be attached to claim form.

Rx ______________

Date Filled __/__/____ Day Supply ___ uantity ______

Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost
	Total charge	

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 or need to submit claims under Coordination of Benefits rules.
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.

. 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.

Additional Coordination of Benefits Instructions

Another Health Plan Paid

You must first submit the claim to the primary insurance carrier. nce the statement from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipts in the spaces provided at the top of this page, and attach the statement from the primary plan, which clearly indicates the cost of the prescription fYdRoScfRfScfR SbfYdRt mfYdRsScfRpScfRaScfRcScfReScfRsScfR SbfYfReScfR SbbRsScfRcgScfReScfR,S