Prescription Drug Reimbursement / Coordination of Benefits Claim Form EXPRESS SCRIPTS® An incomplete form may delay your reimbursement. See the back for instructions and complete all information. >> Cardholder Information See your prescription drug ID card. 保险持有者信息 >> Claim Receipts Tape receipts or itemized bills on the back. Group No. See back for details. Check the appropriate box if any receipts Member ID or bills are for a: 如果处方药符合下方选项, 请勾选相应选项 Member Name First Last Compound prescription 复合处方药 Make sure your pharmacist lists Street Address ALL the VALID NDC numbers, cost and quantities for each ingredient on the back of this form and attach receipts. Claim will be ZIP City State returned if incomplete. ONE CLAIM FORM PER COMPOUND SUBMISSION >> Patient Information 病患信息 Medication purchased outside 名字 Patient Name First 姓氏 Last of the United States 美国境外购买的处方药 Please indicate: 出生日期 Patient Date of Birth (Month/Day/Year) Country _ Relationship to Plan Member 和保险持有者的关系 Sex 性别 Self 本人 Female 5 Disabled Dependent Currency used _ Allergy medication 过敏处方药 6 Dependent Parent Male 2 Spouse Eligible Child 7 Non-spouse Partner **Coordination of Benefits** 8 Other (Another Health Plan has paid a portion.) Mark the Dependent Student appropriate box for your primary coverage method. **>>>** Pharmacy Information 药房信息 See the back for more information. Name of Pharmacy Is this a coordination of benefits claim? 有无其他保险一同赔付? 如有,请填写 框内部分 Street Address Yes No Another Health Plan paid and you are enclosing City ZIP State a statement that outlines how much you paid and how much the other carrier paid (1) Card Program (3) Telephone (include area code) Express Scripts Mail Order (4) Is this an on-site nursing home pharmacy? □ Yes □ No 药房是养老院的药房吗? Any person who knowingly and with intent to defraud, 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 injure, or deceive any insurance company submits a claim access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will or application containing any materially false, deceptive, be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void. incomplete, or misleading information pertaining to such NCPDP/NPI Required claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal Signature of Pharmacist or Representative (Required) or civil penalties, including fines and/or imprisonment or denial of benefits. Please tape receipts on the back of this page. 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.* 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 仅限复合处方药填写

- 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
	Total charge	