EXPRESS SCRIPTS®

Medicare Part-D Prescription Drug Claims Form

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

A pharmacy prescription receipt or a patient history print out from the dispensing pharmacy is required for each prescription purchased at a pharmacy. For Medicare Part-D Drugs & Services NOT Purchased at a Pharmacy, a bill/invoice is required for all requests for payment such as claims for vaccines from a physician or claims for Medicare Part-D drugs from a hospital or clinic. The Medicare Part-D drugs you are requesting payment for must be clearly identified on the invoice and include the following information: Dispense date, eleven digit National Drug Code (NDC), medication name, strength, dosage, quantity, days' supply, amount paid, prescriber name, and the prescriber National Provider Information number (NPI#).

- **Please submit your receipts TAPED to a separate piece of paper with this form.**
- **Complete Step 1: Member Information**
- **Complete Step 2: Check Reason for Out of Network Purchase**
- **Complete Step 3: When you need to enter information missing from your receipt OR Step 3 can be completed by your pharmacist or physician IF you do not have receipts.**
- **Complete Step 4: Complete only IF Medicare Part-D is NOT your primary insurance**
- **Complete Step 5: Signature**

STEP 1 CARDHOLDER/MEMBER INFORMATION

(To be completed by member)

Cardholder ID #

Group number

Cardholder's name *(Last)*

(First)

(MI)

Street address

City

State

Zip

STEP 2 OUT-OF-NETWORK COVERAGE

(To be completed by member)

Claims for Part-D covered drugs dispensed by a non-participating pharmacy will be processed for the reasons below.

Please check the box for the option that best describes your situation:

☐ **A.** I traveled outside my plan's service area and ran out of (or lost) my medication or I became ill and could not access a network pharmacy.

☐ **B.** I was unable to obtain my medication in a timely manner within my service area (There was no network pharmacy within a reasonable driving distance that provides 24/7 service).

☐ **C.** My medication is not stocked regularly at an accessible network or mail-order pharmacy.

☐ **D.** While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.

☐ **E.** I received a vaccine at my doctor's office.

☐ **F.** I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

STEP 3 **ENTER INFORMATION FOR: PRESCRIPTION, VACCINES OR COMPOUND DRUGS**

Drug Name & Strength	NDC National Drug Code	Quantity Dispensed	Ingredient Cost	Day's Supply	Vaccine Administration Fee or Dispensing Fee	Total Cost

Pharmacy name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Pharmacy NPI number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Physician NPI number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Physician name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

To be completed and signed by pharmacist or physician if receipts are not submitted

Pharmacist or Physician signature ____

STEP 4 **OTHER INSURANCE COVERAGE** *(DO NOT complete Step 4 if Medicare Part-D is your primary insurance)*

Is the patient eligible for primary prescription-drug coverage from another provider? Y ☐ N ☐

If yes, did the patient submit the claim to this other provider? Y ☐ N ☐ *(If yes, INCLUDE THE EXPLANATION OF BENEFITS from the other provider.)*

Did the other insurance carrier pay as the primary insurer? Y ☐ N ☐

STEP 5 **SIGNATURE** *(Please DO NOT tape receipts over your signature)*

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Signature ______________________________ Date (Month/Day/Year) ☐☐ ☐☐ ☐☐

Please note: Claims missing information may be returned or payment may be denied

Mail this claim to:
Express Scripts
ATTN: Medicare Part-D
P.O. Box 2858
Clinton, IA 52733-2858

You may also fax your claim form to: 608.741.5483. Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Reimbursement request may be submitted up to 36 months past the dispense date of the drug or service.

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