

**PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE
FORM ON REVERSE SIDE.**

Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit)

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card).

**IMPORTANT: CLAIM FORM MUST BE SIGNED
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED**

Patient Information (Complete a section for each family member who is submitting prescriptions)

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include:

Prescription receipts/labels or a patient history printout from your pharmacy, **signed** by the dispensing pharmacist. All prescription information should include:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the following information may be returned or payment may be denied)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please DO NOT staple or glue.*

Reason for claim submission or special notes

This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-866-291-2607.

Please return this claim to: Express Scripts, Inc.
Member Reimbursements
P.O. Box 66583
St. Louis, MO 63166-6773