Health

EXPRESS SCRIPTS®
Charting the Future of Pharmacy

Clear form

Express Scripts - **BOR**
Mail Route # BOR-01
PO Box 390863
Bloomington, MN 55439-0873
Member Services Phone Number: 1-877-650-9341

Member Reimbursement Claim Form

IMPORTANT INSTRUCTIONS

When should you use this form?

1) Between the effective date of your eligibility with your prescription program and the receipt of your pharmacy ID card;
2) If you are unable to use an In-Network pharmacy; or
3) If you are asked to pay for the total cost of your prescription at a participating pharmacy.

There will be no Coordination of Benefits (COB) for allowed pharmacy charges between the Board of Regents pharmacy plan and another pharmacy/medical plan in which the member may be enrolled.

Your claim cannot be processed unless this form is complete.

- A separate claim form must be completed for each member/patient. Please complete all of the information requested under Part A.
- Please complete Part B by using the information on the packaging of your prescription or by using your pharmacy receipt. You may ask your pharmacist for assistance.
- Please tape your pharmacy receipt(s) to 81/2 by 11 sheet of paper and include it with this form.
- Please review, sign, and mail your 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

First name _____ M I _____ Last name _____

Mailing Address _____

City, State, Zip Code _____

Telephone Number

Did you (member/patient) use a network pharmacy? ❑ **Yes** ❑ **No**

Does the member/patient reside in a nursing home? ❑ **Yes** ❑ **No**

Does the member/patient reside in an assisted living care facility? ❑ **Yes** ❑ **No**

REQUIRED INFORMATION

Part A

Pharmacy/Physician/Member/Patient Information

Pharmacy NCPDP # ___ ___ ___ ___ ___ ___ ___ **Name of Pharmacy** _____
(Please ask your pharmacist or check your pharmacy receipt)

Physician Name _____ **Physician DEA #** ___ ___ ___ ___ ___ ___ ___ ___ ___
(Please ask your physician for this number)

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

Date of Birth_____/_____/_____ **Gender: M** ❑ **F** ❑ **Relationship:** ❑ **Member** ❑ **Spouse** ❑ **Dependent**

Part B

Prescription Information – Please 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

AUTHORIZATION: I authorize the release of any information necessary to process this claim and I also certify that the above information is correct. A photocopy of this authorization shall be as valid as the original.

Member or Authorized 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_____ 01/01/2001