Medicare Part D Coordination of Benefits / Direct Claim Form

Express Scripts Medicare™ (PDP)

See the back for instructions. Complete all information. An incomplete form may delay your reimbursement. If you are not a Medicare Part D member and complete this form, it may delay the processing of your claim.

Member/Subscriber Information *See your prescription drug ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last): _____

Street Address: _____

City: _____ ☐☐ State ☐☐☐☐☐ Zip

Date of Birth **(MM/DD/YYYY)** _____

Pharmacy Information

Name of Pharmacy: _____

Street Address: _____

City: _____ ☐☐ State ☐☐☐☐☐ Zip

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

National Provider ID Number: _____

Prescribing Physician Information

Physician Name: _____

Physician Address: _____

City: _____ ☐☐ State ☐☐☐☐☐ Zip

NPI/DEA/State License #: _____

Does this claim qualify for coverage?

You may submit a claim for Part D–covered medication dispensed by a nonparticipating pharmacy only for the reasons listed below. Please check the box that applies to your situation:

- ☐ **A.** I traveled outside my plan's service area and ran out of (or lost) my medication/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. (Be sure to include the receipt from the physician and complete the PHARMACY INFORMATION section on the back.)
- ☐ **F** I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

Supplemental Benefits

Did another insurance carrier already pay a portion of your drug cost, and you are submitting this claim for additional payment? ☐ Yes ☐ No

If you mark Yes, enclose a statement that outlines how much you paid and how much the other insurance carrier paid. Read the back of this form for more information.

Acknowledgment

I certify that the medication described above 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 also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. 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 **X** _____

Medicare Part D Coordination of Benefits / Direct Claim Form Step-by-Step Instructions.

Complete all applicable sections on side 1. For standard prescriptions the pharmacy receipts must include:

- Date prescription filled • Doctor name and ID number • Quantity and days' supply
- Prescription number (Rx number) • DAW (Dispense As Written) • NDC number
- Pharmacy name and address • Name of drug and strength • Amount paid
- You must complete a separate claim form for each pharmacy used.
- Tape pharmacy receipts to an additional piece of paper; do not staple.
- You must submit claims no later than 36 months from the date of purchase.
- Read the acknowledgment at the bottom of side 1; sign and date the form.
- Do not combine claims for different members in the same fax submission.

Mail Form To:

Express Scripts
P. O. Box 2858
Clinton, IA 52733-2858
or
Fax: (608) 741-5483
Please send one claim per fax

Prescription Information for Compound Prescriptions ONLY

Rx #		**Date Filled**		**Day's Supply**	
VALID 11-digit NDC #			**Quantity**	**Price**	
		Total quantity			
		Compound fee			
		Total charge		$	

- Name of each ingredient contained in the prescription
- A valid NDC number for each ingredient
- For each NDC number, indicate cost per ingredient.
- The quantity of each ingredient (Note: If you need help getting this compound drug information please contact your pharmacist

Supplemental Benefits: You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Vaccine Claim Information: (Required information. Please submit one form per vaccine.) Please fill in the vaccine name, NDC number, quantity, vaccine charge, and administration fee in the blank space provided below. You should enclose the receipt(s) for your vaccine with this form. Only vaccine claims covered under Part D should be submitted on this form. Some vaccines are covered under Part B (example: flu, PNEUMOVAX)

Vaccine	**Valid 11-digit NDC#**	**Quantity**	**Day's Supply**	**Date Filled**	**Vaccine Rx#**	**Admin Fee**

Other Insurance Company: **Request for a True Out-of-Pocket (TrOOP) Update - Other Coverage**

This section is not required for a direct claim reimbursement. Please complete this section only if you have a request for a TrOOP update. (If you have a direct claim and this section is completed, your reimbursement will be delayed.)

1. Please include all applicable pharmacy receipts and/or Explanation of Benefits (EOB) statements with this form. Check off which of the payers below paid your claim.

☐ A discount card ☐ A Patient Assistance Program (PAP) ☐ A secondary payor

2. Other Policy Number: _____ Other Policy Holder _____

Name: _____

Date of Service	Drug Name	Rx Number	Charge	Amount Patient Paid	Amount Other Payer Paid