

Prescription Drug Reimbursement Form

Please complete all information.
An incomplete form may delay your reimbursement.



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

Group No. **H M R K 0 0 1**

Member ID

Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

- | | | |
|---------------------------------|--|---|
| Sex | Relation to Plan Member | |
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male | <input type="checkbox"/> 2 Spouse | <input type="checkbox"/> 6 Dependent Parent |
| | <input type="checkbox"/> 3 Eligible Child | <input type="checkbox"/> 7 Other |
| | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Non-spouse Partner |

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

I hereby certify that the charge(s) shown for the medications prescribed is/are correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Pharmacist or Representative (Required) NABP Number

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for 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.

X _____
Signature of Member

Claim Receipts

Tape claim receipts or itemized bills on the back.

Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

- Is a compound prescription.**
Make sure your pharmacist lists ALL the VALID NDC numbers and quantities for each ingredient on the back of this form and attach receipts. **Claim will be returned if incomplete.**

ONE CLAIM FORM PER COMPOUND SUBMISSION.

- Was purchased outside the U.S.A.**

If so, please indicate:

Country _____
Currency used _____

- Is for treatment of an allergy.**

Please tape receipts on the back

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

*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 1 800 922-1557 for assistance.

