

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.



Zip

☐ 8 Other

C1001 9-12

Please tape receipts on the back.

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

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- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the “metric quantity” expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx #		Date filled		Days' supply	
VALID 11-digit NDC #			Quantity	Price	
Total quantity					
Total charge					

Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
 - The pharmacy does not accept your Express Scripts prescription drug ID card, or
 - You have not received your Express Scripts prescription drug ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
4. You must submit claims within 1 year of date of purchase or as required by your plan.

5. **Be sure your receipts are complete.**
In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.
7. Return the completed form and receipt(s) to: _____

Express Scripts
P.O. Box 14711
Lexington, KY 40512

* **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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