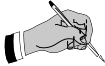


Cardholder's Name (Last, First, MI)	Cardholder's Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
Patient Name (Last, First, MI)	Date of Birth	Gender M F	Patient ID Number
<input type="checkbox"/> Check if new address Street _____ City/State _____ Zip Code _____ Daytime Telephone (_) _____			
Health Plan Name		Group Number	
♦ Is Medicare Part D the patient's primary coverage? <input type="checkbox"/> yes <input type="checkbox"/> no ♦ Does the patient have primary coverage under another plan, with Medicare considered secondary? <input type="checkbox"/> yes* <input type="checkbox"/> no *If yes, please attach an explanation of benefits from your primary carrier.			

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc., the company chosen by my Plan Sponsor to manage my pharmacy benefit, and my Plan Sponsor. 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.



Cardholder's Signature and Date _____

PRESCRIPTION INFORMATION

Number of receipts attached: _____

→ IMPORTANT ← All prescription claims must have prescription receipts/labels which include:

♦ Pharmacy Name/Address	♦ Drug Name, Strength and NDC	♦ Days Supply
♦ Patient's Name	♦ Date Filled	♦ Price
♦ Script Number	♦ Quantity	

Please note: Above claim detail information is necessary in order to process your claim request.

- ♦ **Please tape receipts to separate piece of paper.**
- ♦ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
 (With the exception of diabetic supplies)



♦ Is claim for **DIABETIC SUPPLY**? yes no. If **Yes**, please ask your pharmacist which supplies are covered under your Part-D plan. Please ensure receipts include:

Pharmacy Name/Address • Date Filled • Type of Insulin and/or Type of supply
 • Quantity • Days Supply • Price • Patient's Name.

Cash register receipts are acceptable but

Pharmacist Signature is required if any information is handwritten.

♦ Is this claim for **allergy serum or vaccination**? yes no

If yes, please supply type or additional information: _____



P.O. Box 66752
St. Louis, MO 63166-6752

Please return this claim to:
Express Scripts, Inc
P.O. Box 66752
St. Louis, MO 63166-6752
ATTN: MED-D Accounts

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

Cardholder/Patient Information

The Cardholder is the insured member. Please complete a separate claim form for each patient.

1. Print Cardholder's name (last, first, middle initial).
2. Identify Cardholder's relationship to patient.
3. Print Patient's name (last, first, middle initial).
4. Print Patient's date of birth.
5. Circle the correct letter to indicate if Patient is male or female.
6. Print Patient's ID number (found on prescription drug or health insurance card).
7. Print mailing address and daytime telephone number. Please check box if this is a new address.
8. Indicate health plan name and group number (refer to prescription drug or health insurance card) under which patient is covered.
9. Indicate if Medicare Part D is Patient's primary insurance
10. Indicate if Patient has primary coverage under another plan. If Patient has primary coverage under another plan, Patient must submit claims with a copy of the explanation of benefits from the primary carrier.
11. **CLAIM FORM MUST BE SIGNED.** Unsigned claim forms cannot be processed and will be returned.

Prescription Information

1. Indicate number of receipts submitted for reimbursement consideration

In order to be processed, you will need to obtain prescription receipts or a patient history printout from your pharmacy that includes the following prescription detail:

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

Please note:

- * It is preferable to have receipts unattached or taped to a separate piece of paper. *Please DO NOT staple or glue.*
2. Indicate if claim is for diabetic supply. If diabetic supply, please provide drug detail. Please note, only some diabetic supplies are covered under your Medicare Part D plan. Please seek assistance from your pharmacist for further guidance.
 3. Indicate if claim is for allergy serum or vaccination and if flagged as yes, please provide drug detail.

Questions? Call Express Scripts' Customer Service Department at



REMINDER: Remove this section before mailing to save these telephone numbers.

Questions about your Mail Order or Mail Order service? Call Express Scripts Home Delivery Pharmacy at 1-866-553-4125, Monday through Friday 8 am to 5 pm Central time. Hearing Impaired users should call 1-800-899-2114.

It is very important that you fill in this table as shown (●). Failure to provide complete and accurate information may prevent the pharmacy from detecting drug related problems.

DRUG ALLERGIES	List other Allergies here:	<input type="radio"/> No Known Allergies
		<input type="radio"/> Acetaminophen/Tylenol®
		<input type="radio"/> Amoxicillin
		<input type="radio"/> Aspirin
		<input type="radio"/> Cephalosporin (i.e., Keflex®, Cephalexin)
		<input type="radio"/> Codeine
		<input type="radio"/> Erythromycin, Biaxin®, Zithromax®
		<input type="radio"/> NSAIDs (i.e., Ibuprofen, Naproxen)
		<input type="radio"/> Oxycodone (i.e., OxyContin®, Percocet®)
		<input type="radio"/> Penicillin
	<input type="radio"/> Sulfa	
	<input type="radio"/> Tetracycline (i.e., Doxycycline, Minocycline)	
HEALTH CONDITIONS	List other Health Conditions here:	<input type="radio"/> No Known Health Conditions
		<input type="radio"/> Arthritis (715.9)
		<input type="radio"/> Asthma (493.9)
		<input type="radio"/> Chronic Bronchitis or Emphysema (496)
		<input type="radio"/> Depression (311)
		<input type="radio"/> Diabetes Type I (250.01)
		<input type="radio"/> Diabetes Type II (250.00)
		<input type="radio"/> Epilepsy/Seizures (345.9)
		<input type="radio"/> GERD (530.81)
		<input type="radio"/> Glaucoma (365.9)
		<input type="radio"/> High Cholesterol (272.9)
		<input type="radio"/> Hormone Replacement Therapy (627.9)
		<input type="radio"/> Hypertension (401.9)
	<input type="radio"/> Thyroid: Low (244.9)	
OTC	List other OTC that you take on a regular basis:	<input type="radio"/> No Over-the-Counter Medications
		<input type="radio"/> Acetaminophen/Tylenol®
		<input type="radio"/> Advil®/Aleve®/Motrin®
		<input type="radio"/> Aspirin/Excedrin®
DEVICES	List Medical Devices here:	<input type="radio"/> No Medical Devices
		Medical Devices (i.e., Glucose Testing Device, Insulin Pump, Nebulizer) and specify brand name and model.
OTHER	List other Prescription Medications here:	<input type="radio"/> No Other Prescriptions
		Prescription Medications not filled through Express Scripts Pharmacy.
CAPS		<input type="radio"/> I want non-child resistant caps for all future orders.

FDA approved generic medications will be dispensed when allowed by your doctor, subject to the terms outlined in your plan. I certify that all the information on this form is correct. I permit Express Scripts Inc. to release all information on this form concerning prescription orders to my plan sponsor, administrator or health plan for the purpose of payment, treatment, or health care operations.

Signature Required

MLR-SCAN MEDICARE (MAILER) 07/01/2008

BACK

Moisten and fold this flap to seal return envelope.



EXPRESS SCRIPTS®
HOME DELIVERY SERVICE
SCAN
PO BOX 52082
PHOENIX AZ 85072-2082



Postage
Required
Post Office will
not deliver
without proper
postage

