Prescription Drug Reimbursement / Coordination of Benefits Claim Form

WELLFLEET® RX PLAN EXPRESS SCRIPTS®

Did you know that you can now submit your prescription claims to us electronically?
Login to express-scripts.com and select Benefits ➔ Forms & Cards

›› Cardholder Information *See your prescription drug ID card.*

Group No.

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

- ☐ Female
- ☐ Male

Relationship to Plan Member

- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Non-spouse Partner
- ☐ 8 Other

›› 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 medication(s) prescribed is 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)**

NCPDP/NPI Required

›› Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.
Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID NDC numbers, cost 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

☐ **Medication purchased outside of the United States**
Please indicate:
Country _____
Currency used _____

☐ **Allergy medication**

Coordination of Benefits

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Mail Order (4)

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.†

Please tape receipts on the back of this page.

›› Acknowledgment

I certify that the medication(s) described 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 certify that the medication(s) described were not for an on-the-job injury. *By completing this form, 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

Date

*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 800.922.1557 for assistance.