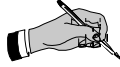


CLF705 (05/03)

Cardholder's Name (Last, First, MI)	Date of Birth	Gender M F	Cardholder ID Number
Address Street _____		<input type="checkbox"/> Check if New Address	
City/State _____		ZIP Code _____	Daytime Telephone (____) _____
Employer _____	Insurance Carrier _____	Group Number _____	

PLEASE SIGN AND DATE HERE: Acknowledgement: I certify the above is complete and correct, that I am eligible for drug benefits, and that I am claiming benefits only for charges incurred by the Patient(s) named below and that the medications are not for an on the job injury or covered under another benefit plan. Any person who knowingly, 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 _____

Date _____

Patient Information (please list information for each patient submitting claims)

1	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number of Receipts Attached
Pharmacy Name, Address and NCPDP#:				Physician Name (name of prescribing doctor) and DEA#:	

2	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number of Receipts Attached
Pharmacy Name, Address and NCPDP#:				Physician Name (name of prescribing doctor) and DEA#:	

3	Patient's Name	Relationship to Cardholder?(circle) Self, Spouse, Child, Domestic Partner	Gender (circle) M F	Date of Birth	Total Number of Receipts Attached
Pharmacy Name, Address and NCPDP#:				Physician Name (name of prescribing doctor) and DEA#:	

Is claim for Diabetic Supply? Yes No. If **Yes**, Patient's name _____
 Type of supply (lancets, syringe, etc.) _____ Quantity _____ Days Supply _____

Does the patient reside in an assisted living facility? Yes No Is this claim for allergy serum? Yes No

Does the patient have primary prescription drug coverage through another insurance carrier? Yes No

Did the patient submit this claim to the other carrier? Yes No *If yes, please attach an explanation of benefits from your primary carrier.*

Prescription Information

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

- Pharmacy Name/Address • Date Filled • Drug Name, Strength, and NDC • Rx Number • Quantity • Days Supply • Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

Please tape receipts to separate piece of paper

Patient history print outs from the pharmacy are also acceptable but **MUST** be signed by the Pharmacist.

CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

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

Cardholder's Information (The cardholder is the insured member whose employer provides this benefit.)

1. Print cardholder's name (last, first, middle initial)
2. Print cardholder's date of birth
3. Circle the correct letter to indicate if cardholder is male or female
4. Print cardholder's ID number (found on prescription drug or health insurance card)
5. Print cardholder's mailing address and telephone numbers. Check box if this is a new address
6. Indicate cardholder's employer, insurance carrier and group number (refer to drug card)

**IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED**

Patient Information (Complete a section for **each** family member who is submitting prescriptions.)

1. Print patient's name
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient
3. Print pharmacy name and address and the prescribing doctor and DEA number used by each patient.

Specific Claim Information

1. Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information

Each submission must include:

Prescription receipts/labels **or** a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

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

(Please note that claims received missing any of the above information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please DO NOT* staple or glue.

Reason for claim submission or special notes

This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 800-585-5794

Visit our Website: www.express-scripts.com

Please return this claim to:
Express Scripts, Inc.
P.O. Box 66583
St. Louis, MO 63166-6583
Attn: Claims Department