

STEP 4**AUTHORIZATION***(to be completed by pharmacist/physician if pharmacy receipts are not submitted)*Pharmacy name National Provider (NPI) number Pharmacist/physician name Address City State ZIP

Pharmacist/physician signature _____

*Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of your prescription drug plan administrator.***STEP 5****SIGNATURE****PLEASE SIGN AND DATE HERE:** I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. 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 _____ Date (Month/Day/Year) **PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.**

- Please print clearly in each box, being careful not to touch the edges of each box.
- Please do not highlight the claim form or the prescription receipts.
- Please sign the claim form. Unsigned claim forms cannot be processed and will be returned.
- Please use a separate claim form for each patient (or family member).
- Each submission must include prescription receipts/labels **OR** a patient history printout from your pharmacy, signed by the dispensing pharmacist.
- If you have multiple receipts for the same patient, please attach them to this claim form.
- Please note that claims missing any of the above information may be returned or payment may be denied.
- It is preferable to submit receipts either unattached to this form or taped to a separate piece of paper. Please **DO NOT** use staples or glue.
- If applicable, include **Power of Attorney, Executor of Estate, or Death Certificate** documentation.

Questions? Call Express Scripts at the number on the back of your member ID card.

Please mail this claim to:
 Express Scripts
 ATTN: Commercial Claims
 P.O. Box 2872
 Clinton, IA 52733-2872

Medicare Part D members please mail to:
 Express Scripts
 ATTN: Med D Claims
 P.O. Box 66752
 St. Louis, MO 63166-6752

You may also fax your claim form to:
 608.741.5475.
Please use one claim form per fax. Do not combine claims for different members in the same fax submission.