EmblemHealth®

Pharmacy Services
Prescription Drug Claim Form

INSTRUCTIONS – PLEASE PRINT ALL SECTIONS

1. This form is to be used to seek reimbursement from EmblemHealth for prescription drug costs you paid above the cost-share amounts outlined under your plan's prescription drug benefits.
2. Complete all sections. We need all the information requested to process your claims.
3. Have your pharmacist complete sections C, D1, D2, and D3. Receipts must be attached.
4. Use a separate form for each member/patient. Use a separate form for each pharmacy serving the patient.
5. Send this form by mail or fax to:

Express Scripts
Attn: Medicare Part D
Address: P.O. Box 14718
Lexington, KY 40512-4718
Fax Number: 608-741-5483

6. If you have over-the-counter benefits (which includes coverage for analgesics, proton pump inhibitors, cough/cold medicines, or antacids), attach your itemized receipts and return. You do not need to complete Section C.

If you have questions, call Express Scripts at **800-585-5786** (TTY: **800-899-2114**), 24 hours a day, seven days a week. A representative is happy to help.

A. SUBSCRIBER INFORMATION		
ID #:	**FOR OFFICE USE** Claim #:	
Subscriber's Name (Last) (First) (MI):		
Street Address:		
City:	State:	ZIP:
SUBSCRIBER'S SIGNATURE:		

B. PATIENT INFORMATION		
Patient's Name (Last) (First) (MI):		Patient's ID #:
Date of Birth / /	Sex: ☐ Male ☐ Female	Patient's relationship to insured: ☐ Self ☐ S pouse ☐ Dependent
I certify that all subscriber and patient information is correct and the medication has been dispensed. I authorize release of any information relating to this claim to EmblemHealth and all necessary third parties for purposes of claims investigation and payment, utilization review, and audit.		
PATIENT'S SIGNATURE:		

C. PHARMACY INFORMATION					
NABP #:	Telephone #:	Pharmacy Name:			
Pharmacy Street Address:					
City:			State:	ZIP:	
PHARMACIST'S SIGNATURE:					

D1. PRESCRIPTION INFORMATION					
Date Dispensed:		Name of Medicine:			Rx #:
NDC #:	☐ New ☐ Refill	Qty Dispensed:	Strength:	Days Supply:	Prescription Cost: $.
Prescriber's Name:				Prescriber's State License #:	

D2. PRESCRIPTION INFORMATION					
Date Dispensed:		Name of Medicine:			Rx #:
NDC #:	☐ New ☐ Refill	NDC #:	☐ New	Days Supply:	Prescription Cost: $.
Prescriber's Name:				Prescriber's State License #:	

D3. PRESCRIPTION INFORMATION					
Date Dispensed:		Name of Medicine:			Rx #:
NDC #:	☐ New ☐ Refill	NDC #:	☐ New	☐ Refill	Prescription Cost $.
Prescriber's Name:				Prescriber's State License #:	

The formulary and pharmacy network may change at any time. You will receive notice when necessary.