Express Scripts®

MASSACHUSETTS

DRUG CLAIM FORM

1. Please type or print clearly. **All information in each section must be provided.**
2. **All forms must be accompanied by an original prescription receipts.**
3. **A separate form must be completed for each patient.**
4. **Please tape additional prescriptions on a separate piece of paper.**
5. If you need assistance completing this form, please contact Member Services at the number listed on the front of your card.
   Incomplete information will result in payment delays and returned forms.

Express Scripts USE ONLY

EMPLOYEE / RETIREE INFORMATION

Subscriber ID number

ESI Group Number B C B S M A S

Last Name

Date of Birth – MMDDYY

First Name

Daytime Phone

Street Address

City

State

Zip Code –

PATIENT INFORMATION

Patient Last Name

Patient First Name

Sex: ❑ M ❑ F Date of Birth

Patient's relationship to the employee/retiree:

❑ Employee/retiree ❑ Student
❑ Spouse ❑ Disabled dependent
❑ Child ❑ Adult dependent

PHARMACY INFORMATION

Pharmacy Name:

Address:

City: State:

Zip Code: –

Phone: – –

OTHER INFORMATION

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

Did the patient submit this claim to the other coverage? ❑ Yes ❑ No

If yes, please attach an explanation of benefits from your primary insurance carrier.

Does this patient reside in a nursing home? ❑ Yes ❑ No

Is this claim for allergy serum? ❑ Yes ❑ No

Prescription Information Receipt #1

Complete information below if not found on receipt #1

National Drug Code

Drug Name_____Drug Strength _____

Date of Service Rx#

Quantity Days Supply Amt. Paid

Tape Prescription Receipt #1 Here – No Staples

The receipt(s) must contain the following information:

1. Rx #
2. Date prescription filled
3. Quantity
4. Days Supply
5. National Drug Code (NDC)
6. Name of drug and strength
7. DAW code (if applicable)
8. Amount paid

Prescription Information Receipt #2

Complete information below if not found on receipt #2

National Drug Code

Drug Name_____Drug Strength _____

Date of Service Rx#

Quantity Days Supply Amt. Paid

Tape Prescription Receipt #2 Here – No Staples

The receipt(s) must contain the following information:

1. Rx #
2. Date prescription filled
3. Quantity
4. Days Supply
5. National Drug Code (NDC)
6. Name of drug and strength
7. DAW code (if applicable)
8. Amount paid

Any intentional false statement or alteration of this claim form is a crime under the laws of the commonwealth punishable by fine, imprisonment or both.

To the best of my knowledge the above information is correct and that the patient named is eligible for benefits.

Mail Completed Form To:

Express Scripts/BCBS–MA
Attn: Member Reimbursement
P.O. Box 66773
St. Louis, MO 63166-6773

Signature:_____Date: _____