Pharmacy Benefit Services
Prescription Drug Claim Form

EmblemHealth®

FOR OFFICE USE ONLY
Claim Number

A. SUBSCRIBER INFORMATION

ID #	Claim #
Subscriber's Name (Last) (First) (MI)	
Street Address	
City State ZIP	

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SUBSCRIBER'S SIGNATURE

B. PATIENT INFORMATION

Patient's Name (Last) (First) (MI)		
Date of Birth	☐ Male ☐ Female ☐ X	Patient's ID #
Patient's relationship to insured/subscriber: ☐ Self ☐ Spouse ☐ Dependent		

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PATIENT'S SIGNATURE

C. PHARMACY INFORMATION

NABP/NPI #	Telephone #
Pharmacy Name	
Pharmacy Address	
City State ZIP	

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PHARMACIST'S SIGNATURE:

D1. PRESCRIPTION INFORMATION

Date Dispensed	Rx #	☐ New ☐ Refill	Name of Medication
NDC #	Qty Dispensed	Days Supply	Strength
Prescriber's Name	Prescriber's State License #	Prescription Cost $	

D2. PRESCRIPTION INFORMATION

Date Dispensed	Rx #	☐ New ☐ Refill	Name of Medication
NDC #	Qty Dispensed	Days Supply	Strength
Prescriber's Name	Prescriber's State License #	Prescription Cost $	

IMPORTANT: SEE REVERSE FOR INSTRUCTIONS

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INSTRUCTIONS

PLEASE PRINT ALL SECTIONS

1. This form is to be used to claim prescription drug benefits provided to eligible EmblemHealth subscribers.
2. EmblemHealth subscribers, please complete sections A and B. We need all the information requested to process your claims.
3. Copy subscriber's/patient information from your EmblemHealth identification card.
4. Have your pharmacist complete sections C, D1, and D2. Receipts must be attached.
5. Use a separate form for each patient. In addition, use a separate form for each pharmacy serving the patient.
6. Send the form to: **Express Scripts**
   ATTN: Commercial Claims
   P.O. Box 14711
   Lexington, KY 40512-4711