EmblemHealth®

PRESCRIPTION DRUG CLAIM FORM
Medicare Part D

EXPRESS SCRIPTS®

Please include itemized receipts when using this form. You are not required to use this form. You may send other documentation that provides all of the requested information.

A. Cardholder/Patient Information			Today's Date
Cardholder's Name			
Address	City	State	ZIP Code
Cardholder ID Number	Plan Name		
Patient's Date of Birth / /	Gender ☐ M ☐ F		
Why was the prescription drug card NOT used for this purchase? Please explain below:			

B. Other Insurance Coverage			
Is the patient eligible for primary prescription drug coverage from another provider? ☐ Yes ☐ No If yes, please use that insurance card to complete the fields below. Please also include a copy of the Explanation of Benefits from that provider when submitting this drug claim form.			
Insured's Name (Last, First, MI)			
Other Insurance Company's Name	Member ID	PCN #	Coverage Effective Date ___/___/_____

I certify that the information on this claim form is correct to the best of my knowledge. I authorize the release of any medical information pertaining to this claim to Express Scripts, Inc., its agents or its representatives.

Signature: _____ Date: _____

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

HIP Health Plan of New York (HIP) is a Medicare Advantage organization with a Medicare contract. Group Health Incorporated (GHI) is a standalone prescription drug plan with a Medicare contract. HIP and GHI are EmblemHealth companies.

All beneficiaries must use their plan sponsor's network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply.

Y0026_122678 Group 09/01/2011

Information for your Pharmacist/Physician: By completing Sections C and D, you certify the information correctly represents the amount paid by the member for the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

If more than three prescriptions are being submitted, please complete additional claim form(s).

C. Claim(s) Information

1. Is this a compound Rx? ☐ Yes ☐ No	Fill Date ___/___/_____	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name		Prescriber ID
Was this prescription filled in a foreign country? ☐ Yes ☐ No			Prescriber Fax Number		
2. Is this a compound Rx? ☐ Yes ☐ No	Fill Date ___/___/_____	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name		Prescriber ID
Was this prescription filled in a foreign country? ☐ Yes ☐ No			Prescriber Fax Number		
3. Is this a compound Rx? ☐ Yes ☐ No	Fill Date ___/___/_____	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name		Prescriber ID
Was this prescription filled in a foreign country? ☐ Yes ☐ No			Prescriber Fax Number		

Compounds: Even if you have itemized receipts, the following must be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications.

NDC Number	Ingredient	Quantity	Cost
Compounding Fee			

D. Authorization

National Provider Indicator (NPI) Number		Pharmacy Name	
Pharmacist/Physician Name			
Pharmacy Address	City	State	ZIP Code
Pharmacist/Physician Signature:			

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can request:

1. **Expedited (72 hours):** You, your prescriber, or your representative can ask for an expedited (fast) appeal if you or your prescriber believe that your health could be seriously harmed by waiting up to seven days for a decision. You cannot request a fast appeal if you are asking us to pay you back for a prescription drug you already received. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your appeal.
   - If your prescriber asks for an expedited appeal for you or supports you in asking for one, and says that waiting for seven days could seriously harm your health, **we will automatically expedite your appeal**.
   - If you ask for an expedited appeal without support from your prescriber, we will decide if your health makes an expedited appeal necessary. We will tell you if we do not give you an expedited appeal and we will decide your appeal within seven days.
2. **Standard (seven days):** You, your prescriber, or your representative can request a standard appeal. We must give you a decision no later than seven days after we get your appeal.

What do I include with my appeal request?

You should include your name, address, member number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescriber must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

How do I request an appeal?

For an Expedited Appeal: You, your prescriber, or your representative should contact us by telephone or fax at the numbers below:

Phone: 1-800-585-5786	**Fax: 1-877-852-4070**

For a Standard Appeal: You, your prescriber, or your representative should mail or deliver your written appeal request to the address below:

Express Scripts, Inc. Att: Pharmacy Appeals – GH3
6625 West 78th St. Mail Route BL0390
Bloomington, MN 55439

What happens next?

If you appeal, we will review your case and give you a decision. If any of the prescription drugs you requested are still denied, you can request an independent review of your case by a reviewer outside of your Medicare drug plan. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

Contact information:

If you need information or help, call us at:

Phone: 1-800-585-5786	**Fax: 1-800-899-2114**

Other resources to help you:

Medicare Rights Center:
Toll Free: 1-888-HMO-9050

Medicare:
Toll Free: 1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

Elder Care Locator
Toll Free: 1-800-677-1116

EXPRESS SCRIPTS®

P.O. Box 66752
St. Louis, MO 63166-6752

Mailing Address Block
Do Not Use

Please return this claim form to:

Express Scripts, Inc.
PO Box 66752
St. Louis, MO 63166-6752
ATTN: MED-D Accounts

INSTRUCTIONS FOR USING THIS FORM:

1. Present your prescription drug card at the pharmacy to avoid having to submit this drug claim form for reimbursement.
2. If necessary, use this form for prescription claims that were purchased without presenting your card due to an emergency or were purchased at an out-of-network pharmacy. For consideration of payment, you must send Express Scripts all of the requested information for each claim to the address below. Express Scripts will process your claim(s) within 14 days of receiving all of the necessary information and tell you their decision. Express Scripts will contact you if your information is incomplete and we are not able to get the information from your pharmacy or doctor.
3. **Complete all items in sections (A) and (B).** Sign the form in the area provided. Enclose original receipts with this form. Be sure your itemized receipts include the following:
   1) Pharmacy name
   2) Pharmacy NABP number
   3) Prescription number
   4) Date of purchase
   5) Medicine name – Please make copies for your records.
   6) Strength
   7) Quantity dispensed
   8) Physician ID number
   9) Total amount charged for each prescription

4. If your claim is for a compound drug, please have your pharmacist or physician complete sections (C) and (D) of this form even if you have included the receipts.
5. If you are not able to submit original pharmacy receipts, please have your pharmacist or physician complete sections (C) and (D) of this form.
6. Items not covered under your prescription benefit plan should not be submitted for reimbursement, including durable medical equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan.
7. Mail the completed form to:
   Express Scripts, Inc.
   PO Box 66752
   St. Louis, MO 63166-6752
   ATTN: MED-D Accounts