

# Pharmacy Benefit Services Prescription Drug Claim Form



**EmblemHealth®**

**FOR OFFICE USE ONLY**

Claim Number

**A. SUBSCRIBER INFORMATION**

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

City	State	ZIP
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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)
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Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X	Patient's ID #
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Patient's relationship to insured/subscriber:  Self  Spouse  Dependent

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. 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/NPI #	Telephone #
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Pharmacy Name

Pharmacy Address

City	State	ZIP
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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.

PHARMACIST'S SIGNATURE:

**D1. PRESCRIPTION INFORMATION**

Date Dispensed	Rx #	<input type="checkbox"/> New <input type="checkbox"/> Refill	Name of Medication
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NDC #	Qty Dispensed	Days Supply	Strength
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Prescriber's Name	Prescriber's State License #	Prescription Cost \$
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**D2. PRESCRIPTION INFORMATION**

Date Dispensed	Rx #	<input type="checkbox"/> New <input type="checkbox"/> Refill	Name of Medication
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NDC #	Qty Dispensed	Days Supply	Strength
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Prescriber's Name	Prescriber's State License #	Prescription Cost \$
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**IMPORTANT: SEE REVERSE FOR INSTRUCTIONS**

80-6627 12/20

## 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