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.

EMPLOYEE / RETIREE INFORMATION

PATIENT INFORMATION

PHARMACY INFORMATION

Other Information

Prescription Information Receipt #1

Tape Prescription Receipt #1 Here – No Staples

Prescription Information Receipt #2

Tape Prescription Receipt #2 Here – No Staples

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: __________________________