# Medicare Part D Prescription Drug Claim Form



Section 1 – Cardholder Information

Cardholder # Group # Cardholder Name (*Last, First*) Date of Birth Street Address Phone # City State Zip



Section 2 – Other Prescription Drug Coverage *(Check all that apply)*

 This claim was submitted to or partially paid for by another insurance plan.

*(Be sure to include the Explanation of Benefits from the other insurance company.)*

This prescription was purchased using a discount card. *(Ex: GoodRx, InsideRx, etc.)*

 Another Insurance Plan paid for this Claim in error and that Plan sent you a Collection Letter.

*(Be sure to include the collection letter with your claim)*



Section 3 – Provider of the Prescription

Pharmacy Name Pharmacy NPI Street Address Phone # City State Zip

My physician provided the vaccine or drug. See Section 5 for physician information.



Section 4 – Reason for Purchasing Out of the Plan’s Network

1. I traveled outside my plan’s service area and ran out of (or lost) my medication; or I became ill and could not access a network pharmacy.
2. I was unable to obtain my medication in a timely manner within my service area (there was no network

pharmacy within a reasonable driving distance that provides 24/7 service).

1. My medication is not stocked regularly at an accessible network or mail-order pharmacy.
2. While I was a patient in an emergency department, provider-based clinic, outpatient surgery or other outpatient facility, my medication was dispensed from an out-of-network pharmacy located in one of these institutions, and I could not get my medication filled at a network pharmacy.
3. I received a vaccine at my doctor’s office or pharmacy.
4. I was evacuated or displaced from my residence due to a State or Federally declared disaster or health emergency.

BOB25CE1 CRP2607\_10985 Y0108\_5757-01-0825\_C



Section 5 – Physician Information

Physician Name Physician NPI Physician Address Phone City State Zip



Section 6 – Prescription Detail *(To be completed and signed by physician or pharmacist if receipt is not attached)*

Drug Name NDC Total Paid $ Date of Service Rx # Qty Days Supply **Special Situations:**

 Vaccine Claim: Drug Cost $ Admin Fee $ Total Paid $

 Compound Prescription *(Include a copy of the detailed receipt from the pharmacy showing all ingredients with costs)*

 Medication was Purchased Outside of the U.S.A. *(This includes prescriptions on a cruise ship)*

 Medication was Administered during an Emergency Room Observation Stay or at an Outpatient Facility.

*(See Section 4, Option “D”. Please provide a list of drugs that includes the National Drug Code (NDC) and cost for each drug)*

Pharmacist/Physician Signature NPI Date



Section 7 – Cardholder Signature

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be made according to the limits of your prescription benefit plan and 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. Claims that are hard to read or incom-

plete may be returned or payment denied. If someone is submitting the claim on the beneficiary’s behalf, an Authorization of Repre- sentation form (Form CMS-1696) or a legal document demonstrating representation must be attached. See the instructions for more information.

Warning: Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or appli- cation containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including denial of benefits, fines or imprisonment*.*

Signature Date  Signed by Representative



Section 8 – How to Submit the Claim *(All reimbursement requests must be submitted in writing)*

**Via Mail:**

Express Scripts

ATTN: Medicare Part D PO Box 52023

Phoenix AZ 85082

**Via Fax** – You may also fax your claim form to: 1.608.741.5483. Please use one claim form per fax. Do not combine claims for different members in the same fax submission. Reimbursement requests may be submitted up to 36 months from the date of service.

© 2025 Express Scripts® Pharmacy Benefit Services. All Rights Reserved.

# Instructions for Medicare Part D Prescription Drug Claim Form

Purpose

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM.

prescription receipt from the pharmacy and the

The Prescription Drug Claim Form is offered as a tool to assist in getting your request for reimburse- ment paid as soon as possible. Use of the form is not required, but it is strongly encouraged. The information requested is needed to process your claim.

Please print clearly. Please note that missing, in- complete, hard-to-read, or ambiguous documenta- tion can delay the successful processing of your claim.

This form can be used to request reimbursement for any of the following Medicare Part D prescription drug situations:

Routine Prescriptions – You purchased a prescrip- tion from a pharmacy without using your Medi- care Part D benefit card.

Hospital Observation – You were admitted to a hospital or outpatient facility for up to three days for an observation and you were not allowed to bring the drugs you take on a daily basis from home. The are called self administered drugs. Only self administered drugs are covered by Medicare Part D.

Vaccines – You were administered a Medicare Part D approved vaccine. Be sure to check option “E” in **Section 4** and follow these instructions for submitting vaccine claims:

* If the vaccine was supplied and administered by your doctor, include the physician’s invoice, check the box in **Section 3** but leave the rest blank, complete **Section 6** including checking the box for a Vaccine claim and complete the rest of the form.
* If the vaccine was purchased from and adminis- tered by a pharmacy, include the prescription receipt, skip **Section 5,** complete **Section 6** in- cluding checking the box for a Vaccine claim and complete the rest of the form.
* If the vaccine was purchased from a pharmacy but administered by your doctor, include the

physician invoice from the doctor, complete **Section 6** including checking the box for a Vaccine claim and complete the rest of the form.

* If the vaccine was free but there was an admin- istration fee, this fee cannot be reimbursed. An administration fee can only be covered by Medicare Part D if you paid for the vaccine.

Compound Prescriptions – A compound prescrip- tion is composed of multiple ingredients combined to form a treatment that isn’t readily available. If you are not sure whether you received a compound prescription, ask your pharmacist.

Please note: not all plans cover compound pre- scriptions. Special instructions for compound pre- scriptions include:

* Request a receipt from the pharmacy that lists all of the ingredients. The list should include the National Drug Code (NDC), metric quantity and cost for each ingredient. Submit the phar- macy receipt with your claim.
* Check the box for Compound Claim in **Section 6** and complete the rest of the form.

Receipts

A receipt is **required** to be properly reimbursed for a Medicare Part D prescription drug claim. Please note: a cash register receipt is not sufficient. Please tape your receipt(s) to an 8.5x11 sheet of paper or submit a clear photo copy. Keep a copy for your records. Acceptable receipts include:

Prescription Receipt – This receipt is provided by the pharmacy. It shows the pharmacy infor- mation, date of service or fill date, physician, Rx number, drug name, eleven-digit NDC, quantity, days supply and amount you paid. This is usual- ly the receipt attached to the outside of the pre- scription envelope.

*(continued on next page)*

Physician Invoice – This will come from your doc- tor if you have been administered a vaccine. It should provide the doctor’s information (ex. name, address, and phone number), date of ser- vice, drug name, drug NDC, and amount you paid, including any administration fee.

Hospital Invoice – This will be an itemized state- ment from the hospital resulting from an obser- vation stay See **Section 4**, Option D for a defini- tion. Please identify the drugs on the statement for which you are submitting a claim. Only identified drugs will be considered for reim- bursement.

Section 1: Cardholder Information

Please fill in this section completely. This is criti- cal information so that the claim is processed under the benefit to which you are entitled. The Card- holder Identification/ID number and Group number can be found on your Medicare Part D benefit card.

Section 2: Other Prescription Drug Coverage

Check any of the boxes in this Section that apply to your claim.

Section 3: Pharmacy Information

Please provide as much information as possible

about the pharmacy where the drug or vaccine was purchased, including the National Provider Identifi- er (NPI) number. The NPI should be on the pre-

scription drug receipt. Otherwise, the pharmacy can provide it.

Section 4: Out-of-Network Purchase

Please check the reason that best applies to your situation.

Section 5: Physician Information

All of the information requested in this section is critical to successfully processing your claim per Medicare guidelines. Your claim may be denied if the physician information is not provided. You

may have to contact the physician’s office for their address, phone number, and National Provider Identifier (NPI) number.

Section 6: Prescription Detail

Complete this section with information from your pharmacy prescription receipt. As an alternative to a receipt, you can have your doctor or pharmacist

complete and sign this section.

Special Situations – Check any that may apply to your claim and provide the information or docu- mentation that is requested.

Section 7: Cardholder Signature

Please sign the claim form. If someone is submit- ting the claim on the patient’s behalf, please check the Signed by Representative box and provide ei- ther an Authorization of Representation form

(Form CMS-1696) or a legal instrument defining the Representative. Form CMS‑1696 can be

downloaded at [www.cms.gov](http://www.cms.gov/) or obtained by call- ing the Customer Service phone number on your card.

Section 8: Submit the Claim

The claim **must** be submitted in writing. It may be submitted via mail to or via fax as show in this

Section on the Medicare Part D Prescription Drug Claim Form.

Please note: reimbursement requests may be sub-

mitted up to 36 months from the Date of Service.