PRESCRIPTION DRUG CLAIM FORM
DIV PMD

Cardholder's Name (Last, First, MI)	Date of Birth	Gender M F	Cardholder ID Number

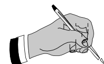
☐ Check if new address

Street____

City/State______________________ Zip Code____________ Daytime Telephone (_)__________

Health Plan Name	Group Number

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me. I have received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. 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 subjects such person to criminal and civil penalties.



Cardholder's Signature and Date ________________________________

Number of receipts attached:

Is claim for **DIABETIC SUPPLY**? ☐ yes ☐ no. If **Yes**, Please provide receipt stating:
Pharmacy Name/Address • Date Filled • Type of Insulin and/or Type of supply
• Quantity •Days Supply • Price •Patient's Name.
Cash register receipts are acceptable but
Pharmacist Signature is required if any information is handwritten.
****Ask your pharmacist how you can purchase diabetic supplies with your prescription card****

Does the patient reside in an **assisted living facility**? ☐ yes ☐no
Is this claim for **allergy serum or vaccination**? ☐ yes ☐no
If yes, please supply type or additional information:___________________________________
Medicare Part D is your primary coverage. Do you have a secondary coverage also? ☐ yes ☐no

➔ IMPORTANT🡐 All prescription claims must have prescription receipts/labels which include:
• Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number
•Quantity • Days Supply • Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

☒ **Please tape receipts to separate piece of paper.**

☒ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.**
(With the exception of diabetic supplies)

For ESI use

Please return this claim to:
UPMC Health Plan
1 Chatham Center
112 Washington Place
Pittsburgh, PA 15219
ATTN: Pharmacy Services

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM ON REVERSE SIDE.

Cardholder Information

The Cardholder is the insured member. Please complete a separate claim form for each patient.

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or health insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's Health Plan Name and group number (refer to drug card).
7. Please include the total numbers of receipts submitted

IMPORTANT: CLAIM FORM MUST BE SIGNED.
UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.

Prescription Information

Each submission must include:
Prescription receipts **or** a patient history printout from your pharmacy:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the above information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper.
Please DO NOT staple or glue.

Reason for claim submission or special notes: (This section can be used for special notes or comments.)