EXPRESS SCRIPTS®

Express Scripts Pharmacy Program, Inc.

OUT-OF COUNTRY CLAIM SUBMISSION FORM

1. Instructions for completing this form are on the reverse side.
2. All forms must be accompanied by an original prescription receipt.
3. A separate form must be completed for each patient.
4. Incomplete information may result in payment delays and returned forms.
5. Country where Rx was filled *must* be included.
6. Have pharmacist or physician assist in completing drug description section if necessary.

Express Scripts USE ONLY

CLAIM NO.

EMPLOYEE / RETIREE INFORMATION

Cardholder ID No. ______________________ Group No. ______________________
9 or more digit number

Name: ______________________ Date of Birth: ______________________
Last First

Address: ______________________

City: __________ State: ______ Zip: __________ Country: ______________________
No abbreviations please

Daytime Phone: (   ) ______________________
It may be needed if we have any questions regarding the claim

To the best of my knowledge the above information is correct and that the patient named is eligible for benefits.

Signature: ______________________ Date: ______________________

PATIENT INFORMATION

Patient Name: ______________________

Date of Birth: ______________________

Sex: ❑ Male ❑ Female

Patient's relationship to the employee/retiree:

❑ Employee/retiree
❑ Spouse
❑ Dependent

Name of country where prescription was filled (no abbreviations):

____

Does the patient have primary prescription drug coverage through another insurance carrier? ❑ Yes ❑ No

Did the patient submit this claim to the other coverage? ❑ Yes ❑ No

If yes, please attach an explanation of benefits from your primary insurance carrier.

OUT-OF-COUNTRY PRESCRIPTION INFORMATION

Date Filled MM/DD/YY	Script Number	Foreign Drug Name and Strength	U.S. Equivalent Drug Name	Quantity	Day Supply	Amount Paid	Currency Exchange Rate	U.S. Rate of Exchange*

** Your reimbursement will be based on this amount*

Mail Completed Form To: Express Scripts, Inc.
P.O. Box 390873
Bloomington, MN 55439-0873
ATTN: Claims Department

OUT-OF-COUNTRY CLAIM SUBMISSION FORM

Instructions for completing this form:
All information must be provided in order to accurately process your claim(s).

EMPLOYEE/RETIREE INFORMATION

Cardholder ID No.	Enter the Cardholder Identification Number which is printed on the front of your enrollment card.
Group Number	Enter your group number as printed on the front of your enrollment card or enter the name of your employer.
Name Address City, State, Zip Date of Birth	This information is applicable to the cardholder.
Country	The name of the country in which the patient resides.
Daytime Phone (Optional)	Enter the telephone number of the employee/retiree. It may be needed if we have any questions regarding the claim.

PATIENT INFORMATION

All information in this section applies to the patient for whom the medication was prescribed.

OUT-OF COUNTRY PRESCRIPTION INFORMATION

This information can be found on your prescription receipt or is available from your pharmacist.

Date Prescription Filled	Enter the date the prescription was filled.
Prescription Number	Enter the number assigned to the prescription by the pharmacy.
Drug Name and Strength	Enter the name of the prescription and the strength dispensed (e.g., Zantac, 150mg). ***Both Foreign name and U.S. equivalent are necessary. If you need assistance obtaining this information please contact your pharmacist or physician.**
Quantity	Enter the number of tablets or quantity of the medication dispensed. Total quantity is listed on the prescription label. Liquids such as cough medicine or vials such as insulin can come in quantities of milliliters (ml) or ounces (oz).
Days Supply	Enter the number of days the medication was intended to be taken.
Amount Paid	Enter the amount that you paid to the pharmacy for the prescription.
Currency Exchange Rate	This is the rate of exchange for converting foreign currency to U.S. dollars. Use the exchange rate in effect the day you received your prescription.
U.S. Rate of Exchange	This is the currency exchange rate multiplied by the amount paid for the prescription. This will be the amount used to determine your reimbursement.

Note: If necessary, Express Scripts will translate your prescription drug receipt; however, this will slow the processing of the claim and our reimbursement to you.