How to complete and submit the Express Scripts form for reimbursement of covered at-home rapid tests.

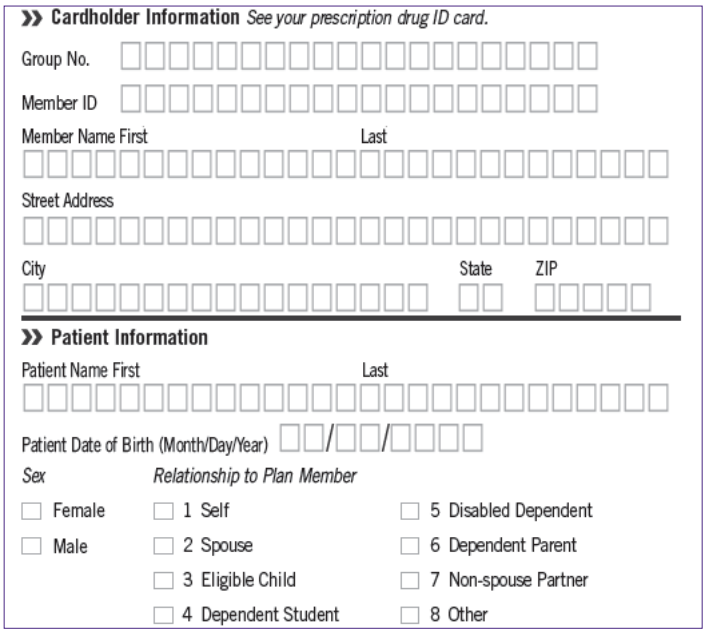
Please be sure to read the testing coverage questions on our websites to carefully see who is covered for at-home rapid tests.

This form must be completed and sent, along with your receipt(s), to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512

You can also fax your materials to **608-741-5475**. If you have questions, please call the number on the back of your member ID card. A Customer Service representative will be happy to help.

This portion asks for your basic information. Not all members will have a Group No. Leave this section blank if you don't see one on your member ID card. Be sure to complete a separate form for each member.



» **Cardholder Information** *See your prescription drug ID card.*

Group No.

Member ID

Member Name First Last

Street Address

City State ZIP

» **Patient Information**

Patient Name First Last

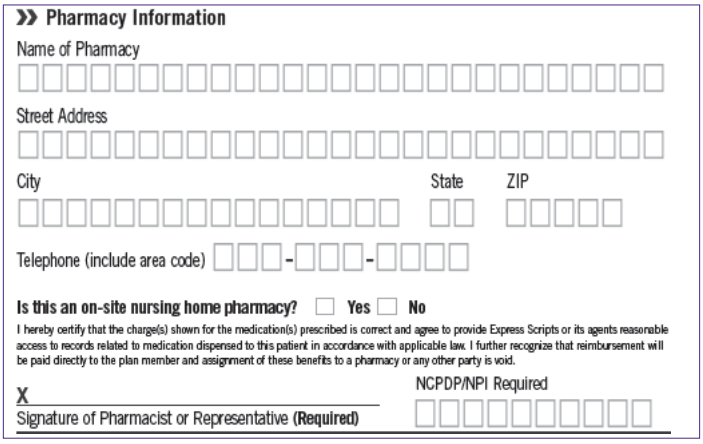
Patient Date of Birth (Month/Day/Year) □□/□□/□□□□

Sex

☐ Female
☐ Male

Relationship to Plan Member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Non-spouse Partner
☐ 8 Other



» **Pharmacy Information**

Name of Pharmacy

Street Address

City State ZIP

Telephone (include area code) □□□-□□□-□□□□

Is this an on-site nursing home pharmacy? ☐ **Yes** ☐ **No**

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide Express Scripts or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X
Signature of Pharmacist or Representative **(Required)**

NCPDP/NPI Required

This is where you purchased your test. You do not need to receive a pharmacist's signature or fill in the "NCPDP/NPI Required" field for at-home rapid tests. Simply tell us where you purchased your at-home rapid test.

Coordination of Benefits

(Another Health Plan has paid a portion.) Mark the appropriate box for your primary coverage method. See the back for more information.

Is this a coordination of benefits claim?

☐ Yes ☐ No

☐ Another Health Plan paid and you are enclosing a statement that outlines how much you paid and how much the other carrier paid (1)

☐ Card Program (3)

☐ Express Scripts Home Delivery (4)

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application 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 fines and/or imprisonment or denial of benefits.†

Please tape receipts on the back of this page.

You do not need to complete these portions of the form.

Be sure to sign and date the form. It is important to only purchase tests for yourself and your dependent(s) that are covered by your plan. These tests are not for resale purposes. Any person who knowingly presents false or fraudulent claim(s) for reimbursement is guilty of a crime and may be subject to criminal or civil penalties.

» Acknowledgment

I certify that the medication(s) described was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I certify that the medication(s) described were not for an on-the-job injury. *By completing this form, I recognize that reimbursement will be paid directly to me and that assignment of these benefits to a pharmacy or any other party is void.**

X ______________________________ ______________________

Signature of Member Date

*If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 800.922.1557 for assistance.

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In this section, we need to know what test you purchased. National Drug Codes (NDC) tell us what product you have purchased. Not all tests currently have NDC codes. Here are the NDC codes that are available now. If your FDA-approved at-home rapid test does not appear on this list, write in the full brand name of your test.

COMPOUND PRESCRIPTIONS ONLY

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

Rx # ☐☐☐☐☐☐☐☐☐☐☐☐

Date Filled ☐☐/☐☐/☐☐☐☐ Day Supply ☐☐☐ Quantity ☐☐☐☐☐

Valid 11-digit Ingredient NDC	Metric Quantity	Ingredient Cost
	Total charge	

Test Name	NDC
Quickvue At-Home Covid-19 Test	14613033972
Inteliswab Covid-19 Rapid Test	8337000158
IHEALTH Covid-19 AG Rapid Test	56362000589
Flowflex Covid-19 AG Home Test	82607066027
Flowflex Covid-19 AG Home Test	82607066026
Ellume Covid-19 Home Test	56964000000
Carestart Covid-19 AG Home Test	50010022431
Binaxnow Covid-19 AG Self Test	11877001140
Pixel Covid-19 Home Collection Kit	42022224
Lucira Check-It Covid-19 Test	10055097004
Everlywell Covid-19 Home Collection Kit	51044000842

Coverage of Rapid, At-Home COVID-19 Tests: Terms and Conditions

Your health plan does not cover OTC COVID-19 At-Home Tests for all purposes. For example, if you purchased a test for the following purposes AND YOU ARE NOT A MEDICAID OR ESSENTIAL PLAN MEMBER, the test is not covered:

1. For use by someone else besides yourself or covered members of your family
2. To meet an employer's testing requirement to be allowed to go to work or for any other employment purpose. If you have a question about testing for employment purposes, contact your employer.
3. To meet a school's or educational institution's requirement to return to school, sports or other related activities
4. For travel purposes
5. For any other public health surveillance purpose
6. To resell the test

There is no coverage if the test has been (or will be) reimbursed from any other source.

The number of covered tests, amount of your health plan's reimbursement, and the date when this coverage is no longer available are set by applicable law.

When you seek reimbursement, we may send you an attestation to complete certifying that the tests you purchased were for a covered purpose.

When you submit a request for reimbursement, the receipt from the seller must show the (1) date of purchase and the (2) price of the test.

Coverage requirements may vary if you are on Medicaid, CHIP, or if you are in the New York Essential Plan. For more information, please go to emblemhealth.com.

Plan terms and conditions apply. See your plan documents for claim filing deadlines, appeals and grievance rights, etc.)

Note: If your health care provider administers the test, these rules do not apply.

For ConnectiCare Members: Any person who, knowingly and with intent to defraud ConnectiCare, Inc. or its members, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of committing a fraudulent insurance act, which is a crime punishable in accordance with applicable law.

For EmblemHealth Members: 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.