EXPRESS SCRIPTS®

Express Scripts manages your prescription drug benefit at the request of your health plan. You recently contacted us to request coverage beyond your plan's standard benefit offering. In order for Express Scripts to review your request on behalf of your plan, please complete the Benefit Coverage Request Form per the instructions below.

Instructions for completing the Benefit Coverage Request Form

Section A: Patient Information:

1. Enter Member I.D. Number and indicate if the coverage request is for a Medicare Prescription Drug Plan claim.
2. Enter Patient's First Name, Middle Initial, Last Name, and Address.
3. Indicate the gender of the patient by checking either the "Male" or "Female" box.
4. Enter the patient's birth date in the box labeled "D.O.B."
5. Indicate the relationship of the patient to the cardholder by checking the appropriate box labeled "Member," "Spouse," "Child," or "Other."

Section B: Requestor Information:

Indicate who is making this coverage request. If your plan is a Medicare Prescription Drug Plan and you are an appointed representative acting on the patient's behalf, you must submit, with this document, form CMS 1696 that can be obtained via: http://www.cms.hhs.gov/CMSForms/.

Section C: Medication Information:

Enter the drug name, strength, dosage form (e.g., tablet, capsule, injection), quantity, quantity taken per day, and date(s) of service for each drug. If the space is not sufficient, you may attach an additional page with these drug details.

Section D: Physician Information:

1. Indicate the name of the physician who has prescribed the medication.
2. Enter the physician's address, city, state, zip code, and National Provider Identifier (NPI). The NPI is a 10-digit number issued to health care providers.
3. Enter the physician's telephone number (including area code).

Section E: Coverage Request:

Describe your coverage request, in detail, in the space provided. If the space provided is not sufficient, you may attach an additional page. In supporting your request for coverage, please provide as much information as possible regarding your health condition (e.g., diagnosis) or circumstance. You must include receipts for reimbursement requests. You may include a letter provided by your physician in support of your coverage request. If required by your plan, Express Scripts will verify the information submitted or obtain additional information from your physician. If your plan is regulated under the Employee Retirement Income Security Act of 1974, as amended (ERISA): Your benefit coverage request will be reviewed according to your plan provisions, and a decision will be sent to you in writing within 15 days of receipt of your written request. If you are requesting reimbursement for a medication already received, a decision will be sent to you in writing within 30 days of your written request.

If your plan is a Medicare Prescription Drug Plan: your benefit coverage request will be reviewed according to your plan provisions, and you, or your representative, will be notified of a decision within 72 hours. If you are requesting an appeal of an initial denial, a decision will be sent to you in writing within 7 days of your written request.

Section F: Mail or fax the completed form to the following address accordingly:

Express Scripts
PO Box 66587
St. Louis, MO 63166-6587
ATTN: Benefit Coverage Review Department
Fax Number: 877.328.9660

Benefit Coverage Request Form

SECTION A Patient Information

MEMBER I.D. NUMBER_____ Medicare Prescription Drug Plan: ☐ Yes ☐ No

PATIENT NAME:_____ _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

☐ Male ☐ Female D.O.B. ☐☐/ ☐☐/ ☐☐☐☐

☐ Member ☐ Spouse ☐ Child ☐ Other

SECTION B Requestor Information - Indicate the person making this coverage request.

REQUESTOR NAME:_____

☐ Patient ☐ Physician ☐ Authorized/Appointed Representative ☐ Other

DAY PHONE: (____)_____ EVENING PHONE: (____)_____

SECTION C Medication Information - List all drugs requiring review.

DRUG NAME/STRENGTH/FORM	TOTAL QUANTITY	AMOUNT PER DAY	DATE(S) OF SERVICE

SECTION D Physician Information

NAME: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE: (____)_____ FAX: (____)_____ NPI: _____

SECTION E Coverage Request

Describe your coverage request. Some examples are: lower copay for brand drug, tiering exception, payment of a non-covered drug, payment of additional quantity, appeal of a reimbursement denial. Please include details of your request using additional pages, if necessary. If available, also provide National Drug Codes (NDCs) and cost of the prescriptions.

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