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: Claimant Information:

1. Enter Member I.D. Number and indicate if the coverage request is for a Medicare Prescription Drug Plan claim. (Note: If your plan is a Medicare Prescription Drug Plan and you have an appointed representative acting on your behalf, your representative must submit, with this document, form CMS 1696 that can be obtained via: http://www.cms.hhs.gov/CMSForms/)
2. Enter Claimant's First Name, Middle Initial, Last Name, and Address.
3. Enter daytime and evening telephone numbers where you can be reached (include area code).
4. Indicate the gender of the claimant by checking either the "Male" or "Female" box.
5. Enter the claimant's birth date in the box labeled "D.O.B."
6. Indicate the relationship of the claimant to the cardholder by checking the appropriate box labeled "Member," "Spouse," "Child," or "Other."

Section B: Medication Information:

1. Enter the drug name, strength, and dosage form (e.g., tablet, capsule, injection) of the drug.
2. Enter the drug quantity and date(s) of service.

Section C: Physician Information:

1. Indicate the name of the physician who has prescribed the medication.
2. Enter the physician's address, city, state, and zip code.
3. Enter the physician's telephone number (including area code).

Section D: 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 E: Complete the form and mail or fax to the following address accordingly:

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

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

Benefit Coverage Request Form

SECTION A Claimant Information

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

CLAIMANT NAME:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

DAY PHONE: _(___)_____ EVENING PHONE:_(___)_____

☐ Male ☐ Female D.O.B. ☐☐/ ☐☐/ ☐☐☐☐

☐ Member ☐ Spouse ☐ Child ☐ Other

SECTION B Medication Information

DRUG NAME, STRENGTH, AND FORM:_____

DRUG QUANTITY:_____ DATE(S) OF SERVICE:_____

SECTION C Physician Information

NAME: _____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP:_____

PHONE: _(___)_____

SECTION D Coverage Request (Check all that apply, and please include any details in the space below.)

☐ Quantity review ☐ Co-pay review/Tiering Exception

☐ Drug Coverage ☐ Other (please specify) _____

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