

Request for a True Out-of-Pocket (TrOOP) Update

This section is not required for a direct claim reimbursement. Please complete this section only if you have a request for a TrOOP update. (If you have a direct claim and this section is completed, your reimbursement will be delayed.)

1. Please include all applicable pharmacy receipts and/or Explanation of Benefits (EOB) statements with this form.
2. Check off which of the payers below paid your claim.

A discount card A Patient Assistance Program (PAP) A secondary payer

3. Other Coverage Section:

Other Insurance Company Name: _____

Other Policy Number: _____

Other Policy Holder Name: _____

Date of Service	Drug Name – Rx Number	Charge	Amount Patient Paid	Amount Other Payer Paid

Pharmacy Information (For Compound Prescriptions ONLY)

For compound prescriptions, you must complete the section to the right, and the pharmacy receipts must include the following:

- Name of each ingredient contained in the prescription
- A valid NDC for each ingredient
- For each NDC number, indicate cost per ingredient.
- The quantity of each ingredient (Note: If you need help getting this compound drug information, please contact your pharmacist.)

Rx #	VALID 11-digit NDC #	Date filled	Quantity	Days' supply	Price
Total quantity					
Compound fee					
Total charge					

Step-by-Step Instructions

- Complete all applicable sections on side 1.
- You must complete a separate claim form for each pharmacy used.
- Tape pharmacy receipts to an additional piece of paper; do not staple.
- You must submit claims no later than 36 months from the date of purchase.
- Read the acknowledgment at the bottom of side 1; sign and date the form.

Return the completed form and applicable receipt(s) to:

Express Scripts
P.O. Box 14718
Lexington, KY 40512

For standard prescriptions, the pharmacy receipts must include:

- Date prescription filled
- DAW (Dispense As Written)
- Pharmacy name and address
- Doctor name and ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- Amount paid

Supplemental Benefits: You must first submit the claim to the primary insurance carrier. Once the Explanation of Benefits (EOB) from the primary plan is received from the primary carrier, complete this form, tape the original prescription receipt(s) on a blank sheet of paper, and enclose the EOB from the primary plan, which clearly indicates the cost of the prescription and what was paid by the primary plan.

Vaccine Claim Information: (Required information. Please submit one form per vaccine.)

Please fill in the vaccine name, NDC number, quantity, vaccine charge, and administration fee in the blank space provided below. You should enclose the receipt(s) for your vaccine with this form. Only vaccine claims covered under Part D should be submitted on this form. You should enclose the receipt(s) for your vaccine with this form. Some vaccines are covered under Part B (example: flu, PNEUMOVAX)

Vaccine Name	Valid 11-digit NDC#	Quantity	Rx#	Days' Supply	Date Filled	Vaccine Charge	Vaccine Admin. Fee

Visit us online anytime at
<http://www.Express-Scripts.com>



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