# Excellus

| **Instructions** Read carefully before completing this form. **All fields must be complete, or the form may be returned to you** | 1. You must submit claims within 15 months of date of purchase as required by your plan |
|---|---|
| | 2. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the following: **1) Date prescription was filled; 2) NDC number (drug number); 3) Amount paid** Your pharmacist can provide the necessary information, if your claim or bill is not itemized |
| | 3. The Plan member should read the acknowledgment carefully, and then sign and date this form |
| | 4. **Return the completed form and receipt(s)** Attention: Claims Dept • P.O. Box 21146 • Eagan, MN 55121-0146 |
| | For questions, contact Customer Service: **1-800-370-5421** |

## Cardholder Information See your member card.

Subscriber ID

Member Name First _____ Last _____

Street Address

City _____ State _____ ZIP _____

## Patient Information

Patient Name First _____ Last _____

Patient Date of Birth (MM/DD/YY) _____ Sex ☐ Female ☐ Male ☐ Transgender

Relationship to Plan Member ☐ 1 Self ☐ 2 Spouse
☐ 3 Eligible Child ☐ 4 Other

## Prescription Details

- List the VALID 11-digit NDC number for EACH prescription (this is usually found on the drug label or outer packaging. The number on the packaging may be less than 11 digits. An asterisk may appear as a placeholder for any leading zeros)
- For each NDC, indicate the Date Filled (MM/DD/YY)
- For each NDC number, indicate amount paid per prescription
- Receipt(s) must be attached to claim form.

| # | Valid 11-digit NDC | Date Filled | Amount Paid |
|---|---|---|---|
| 1 | | / / | $ |
| 2 | | / / | $ |
| 3 | | / / | $ |
| 4 | | / / | $ |
| 5 | | / / | $ |
| 6 | | / / | $ |
| 7 | | / / | $ |
| 8 | | / / | $ |
| 9 | | / / | $ |
| 10 | | / / | $ |

■ **PLEASE TAPE RECEIPTS TO THE NEXT PAGE**

B-7500 (07/20)

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## Acknowledgment

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any information concerning any fact material thereto, for the purpose of misleading, commits a faudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of each violation.

_____

Signature

_____

Date

**Claim Receipts** Please tape your receipts here.
**Do not staple!** If you have additional receipts, tape them on separate pieces of paper.

**Receipts must contain the following information:**

- Date prescription filled
- NDC number (drug number)
- Amount Paid

| Tape receipt for prescription here. | Tape receipt for prescription here. |