

Claim form for drugs over \$9,999.99

Group or Policy No. [_____]

Client ID or Certificate No. [_____]

Carrier ID Number [_____]



Surname [_____]

Name [_____]

Patient Initials	Rel Code	Date of Birth			DIN	Quantity	Days' Supply	Prescription No.	Dispensing Date			Professional fee	Gross Amount	Previous Paid (COB)
		DD	MM	YY					DD	MM	YY			

Pharmacy name, address & provider ID No.	Provincial COB <input type="checkbox"/> Private COB <input type="checkbox"/> CPhA Code <input type="checkbox"/> Comments : (Compound details, etc.) _____ <hr/> I hereby certify tht the drugs claimed as spedified on this form have been provided for the persons identified above. The patient is aware that the information on this form is being transferred to a benefits payment program for adjudication and processing.	Express Scripts Canada 5770 Hurontario Street, 10th Floor Mississauga, Ontario L5R 3G5 Fax No. 905-712-6322 Toll Free Fax No. 1-855-712-6322
Pharmacist Signature: _____		

Relationship Codes 0 - Cardholder 1 - Spouse 2 - Child (Underage) 3 - Child (Overage) 4 - Disabled Dependant	Notes: 1) Please enter the values for Carrier #, Group # and Client ID # exactly as they appear on the Express Scripts Canada Card, in the corresponding fields. 2) Please ensure that your complete Express Scripts Canada Pharmacy ID# is on the form (along with your pharmacy address). 3) Please complete ALL fields on the form.
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