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 DD	MM	YY	DIN	Quantity	Days' Supply	Prescription No.	Dispensing Date DD	MM	YY	Professional fee	Gross Amount	Previous Paid (COB)

Pharmacy name, address & provider ID No.

Provincial COB ☐ Private COB ☐ CPhA Code ☐

Comments : (Compound details, etc.) _____

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.

Pharmacist Signature:

Express Scripts Canada
6985 Financial Drive, Suite 300
Mississauga, ON L5N 0G3

Toll Free Fax Number: 1 844 744-8433

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.