

# PRESCRIPTION DRUG CARD REIMBURSEMENT CLAIM FORM

# PLEASE TYPE OR PRINT CLEARLY.

Not to be used for BlueSCRIPT reimbursement.

PART 1: MEMBER INFORMATION Must be	fully completed for reimb	ursement of your	drug claim.		
Member ID number	Group number		PCN number (bottom fac	ce of ID card) IL	
Member name	Memb	er phone			
Address	City		State	Zip	
Patient Information — Use a separate claim form	n for each family membe	er			
Patient name	Social Security	No	Date of birth		
Relationship:	☐ Other		Patient: 🗖 Mal	e 🗆 Female	
Are any of these medications being taken for an on	-the-job injury? ☐ Yes	s □ No			
Is the medication covered under any other grou	p insurance? □ Yes	s □ No			
If yes, is other coverage: $\ \square$ Primary $\ \square$ Secondary	-				
Name of insurer P					
I certify that all the information entered on this form is correct. In addition, is eligible for drug benefits. I also certify that the medication received is no Shield's use or disclosure of individually identifiable health information, who privacy regulations under HIPAA (Health Insurance Portability and Account	ot for treatment of an on-the-job injur ether furnished by me or obtained fr	y or covered under anoth	er benefit plan. I understand th	at Blue Cross and Blue	
X					
PART 2: IMPORTANT Please remember to inc	clude all <b>original</b> pharmac	cy receipts.	Butto		
Receipts must include: ■ Pharmacy name	■ Prescription ■ [	Orug name	<ul><li>Quantity</li></ul>	■ NDC number	
■ Strength	number ■ [	Date purchased	■ Drug charge	<ul><li>Days supply</li></ul>	
PART 3: PHARMACY INFORMATION Pharma	macist to complete this se	ection ONLY if orig	ginal pharmacy receip	ts are not included.	
<ul> <li>To ensure that your patient receives accurate and timely</li> <li>If compound prescriptions, please enter COMPOUND on the reverse side.</li> <li>Pharmacy name</li> </ul>	RX in the space designated f	or the NDC number	and complete the comp	oound section	
Pharmacy address					
City					
I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the member.					
Signature of Pharmacist or Representative (Required only if original pharmacy	receipts are not included)		Date		
Rx 1  Rx number  Date filled (mo/d)  NDC number	y/year) Prescriber's DE  Drug name and strength		New ☐ Refill  DAW ☐ Compound  Ietric quantity Days s	Prior approval code  For office use only upply Total charge	
Rx 2 Rx number Date filled (mo/d	y/year) Prescriber's DE Drug name and strength		New ☐ Refill DAW ☐ Compound  letric quantity Days s	Prior approval code For office use only upply Total charge	
Rx 3  Rx number  Date filled (mo/d)  NDC number	y/year) Prescriber's DE  Drug name and strength		DAW  Compound	Prior approval code For office use only upply Total charge	

**Fraud Prevention:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IT IS TO YOUR ADVANTAGE TO ALWAYS USE YOUR PRESCRIPTION DRUG CARD TO AVOID FILING PAPER CLAIMS, WHICH DELAYS PAYMENT OF YOUR BENEFITS. Reminder: DO NOT use this form for BlueSCRIPT reimbursement.

### INSTRUCTIONS

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each patient
- Each pharmacy from which you purchase prescription drugs, if original receipt(s) is not attached

# **CLAIM SUBMISSION**

# When submitting a claim, the following information must be included:

- Pharmacy name
- Prescription number
- Date of purchase
- Drug name
- Drug strength
- Quantity
- Drug Charge
- Computer print-out
- Pharmacist's signature and/or original pharmacy receipt(s)
- DO NOT include charges for durable medical equipment which required a prescription to obtain.
- DO NOT submit canceled checks or cash register slips. These are not acceptable as substitutes for original receipts.
- DO NOT submit statement with balance amounts only.

### **HOW TO COMPLETE THIS FORM**

Member/Patient Information — Complete all member and patient information in Part 1 on reverse side.

- The member ID number, group number and PCN number can be found on your member ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Complete a separate form for each family member and for each pharmacy.
- See your benefit administrator for additional claim forms, or log on to our Web site at www.bcbsil.com to download additional forms. Mail your completed form to the address shown below.
- Please make a copy of all documents and receipts before you send in your claim(s) as no documents will be returned.

# PHARMACY INFORMATION

### Pharmacist to complete Part 3 of the form

- Include Rx number(s), drug name(s), strength(s) and date filled.
- Include NDC number(s) for the drug(s) dispensed.
- Indicate NABP number, pharmacy address and phone number.
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables.
- Indicate the days supply (number of days the medication will last).
- Indicate the amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Prime Therapeutics' Contact Center at 800.821.4795.

COMPOUND PRESCRIPTIONS  For pharmacy use only					
NDC number	Drug ingredient	Quantity	Charge		

# **MAILING INSTRUCTIONS**

Mail this form and your original paid pharmacy receipt(s) to:

Blue Cross and Blue Shield of Illinois P.O. Box 64812 St. Paul, MN 55164-0812