

RETAIL PRESCRIPTION DRUG CLAIM FORM Service Benefit Plan for Federal

AREA FOR DOCUMENTS

Employees and Retirees

Federal Employee Program. PLEASE TYPE OR PRINT IN ALL CAPITAL LETTERS. א ומדפואו סר TION

IDENTIFICATION NUMBER

ENROLLEE INFORMATION	
ENROLLEE'S First Last Name Name	Initial R
Street Address Apartment Number, Suite Of	I P.O. Box Number Mail Completed Form To:
City State	Zip Code Service Benefit Plan Retail Pharmacy Program
MARK IF NEW ADDRESS EMAIL ADDRESS	P.O. Box 52057 Phoenix, AZ 85072-2057
PATIENT I	For Information, call 1-800-624-5060
PATIENT'S Last	First
PATIENT'S DATE MONTH DAY YEAR PATIEN Male	"S SEX PATIENT'S RELATIONSHIP TO ENROLLEE Female Self Spouse
employer, a group, such as a professional organization, or any other group	Yes If yes, effective date of coverage Please attach a copy of the NOTICE OF No ////////////////////////////////////
► Did the patient use a prescription drug card from the other insurer when purchas	ng these prescriptions?
PHARMAC	Y INFORMATION
PHARMACY NAME	PHARMACY ID # or NABP # (If Available)
STREET	
	PTION INFORMATION tion, please call your pharmacist. Please see instructions on the reverse side of this claim for
RX NUMBER DATE RX FILLED	\$ AMOUNT CHARGED PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME
1. MONTH DAY YEAR	
RX NUMBER DATE RX FILLED	\$ AMOUNT CHARGED PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME
2. MONTH DAY YEAR	
RX NUMBER DATE RX FILLED	\$ AMOUNT CHARGED PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME
3. MONTH DAY YEAR	
RX NUMBER DATE RX FILLED	\$ AMOUNT CHARGED PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME
4. MONTH DAY YEAR	S AMOUNT CHARGED PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME IS THIS A COMPOUND
ENROLLE	
I certify that the above is complete and correct and that I am claiming ber	efits only for charges incurred by the patient named above. Authorization is herek

given to any provider of service, which participated in any way in my care, to release to the Blue Cross and Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

ENROLLEE'S SIGNATURE	DATE

Instructions

- 1. Please complete a separate claim form for each patient and each pharmacy. Each claim form must be signed.
- 2. When you have completed this form, please include your itemized receipts. Send original receipts only. Photocopies of receipts are not acceptable, except when submitted with another carrier's explanation of benefits or notice of payment. A pharmacist's signature is required on all handwritten receipts. We recommend you keep copies for your records.
- 3. You must answer the other prescription drug insurance questions in the Patient Information Section on the front of this form or your claim will be returned.
- 4. Itemized receipts for covered prescriptions are required and must include the following:
 - NABP number or the current name and complete address of pharmacy
 - Full name of the patient
 - Date filled
 - Name of drug, strength (e.g., 500 mg) and dosage form (e.g., capsules, liquid or cream)
 - Prescription number
 - Quantity
 - Charge for each prescription
- 5. "DAYS SUPPLY" must be included on the claim form. Calculate your days supply like this: QUANTITY ÷ DOSAGE = DAYS SUPPLY QUANTITY - Total number of units (pills, tablets, capsules)

DIVIDED BY

DOSAGE - Total number of doses per day (one a day, 3 times a day) Example: You have 90 tablets and you take 3 tablets per day i.e. $90 \div 3 = 30$ DAYS SUPPLY

- 6. Only claims for prescriptions purchased from a retail pharmacy are to be sent to the address on the front. Claims for all other services should be sent to your local Blue Cross/Blue Shield Plan using a Federal Employee Program Health Benefits Claim Form. Example of claims sent to your local Blue Cross and/or Blue Shield Plan includes:
 - Drugs dispensed by a physician or hospital including allergy sera
 - Home health care medications
 - Durable medical equipment
- 7. Claims must be submitted promptly, but in any case no later than December 31 of the calendar year following the year in which the drug was purchased.

Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine or not more than \$10,000 or imprisonment of not more than 5 years, or both, (18 U.S.C. 1001).

Prescription drug benefits under the Service Benefit Plan are subject to the terms, limitations and exclusions stated in the Service Benefit Plan brochure including "If the provider waives your share" in the Cost Share Section. The Billed charge must be no more than the pharmacy's normal retail charge.