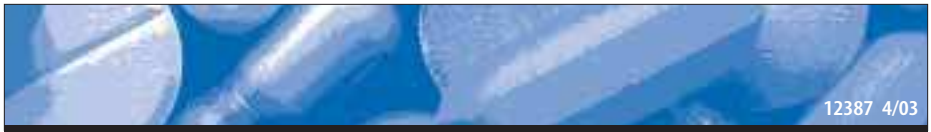
BlueCross BlueShield of Illinois



Prescription Drug Card Reimbursement Claim Form

Not to be used for BlueSCRIPT reimbursement.

Part 1
Member Information

Part 1 must be fully completed to ensure proper reimbursement of your drug claim. Please type or print clearly.

Important! *Please remember to include all original pharmacy receipts.*

Member ID No. _____ *Group No.* _____

Member Name _____ *Address* _____

City _____ *State* _____ *ZIP* _____ *Phone ( )* _____

Patient Information—Use a separate claim form for each family member

Patient Name _____ *Social Security No.* _____ *Date of Birth* _____

Patient: ❍ *Male* ❍ *Female* *Relationship:* ❍ *Member* ❍ *Spouse* ❍ *Child* ❍ *Other* _____

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I understand that Blue Cross and Blue Shield's use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

X _____

Signature of Patient or Legal Representative **Date**

Part 2

If you are including all original receipts, which include:

- *Pharmacy Name*
- *Prescription Number*
- *Date Purchased*
- *Strength*
- *Drug Name*
- *Quantity*
- *Drug Charge*

STOP HERE, *and submit claim with the original pharmacy receipts. It is not necessary to complete Part 3.*

Part 3
Pharmacy Information

Pharmacist to complete this section ONLY if original pharmacy receipts are not included.

- To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below.
- If compound prescriptions, please enter 'COMPOUND RX' in the space designated for the NDC# and complete the compound section on the reverse side.

Pharmacy Name _____ *Pharmacy NABP No.* _____

Pharmacy Address _____ *City* _____

State _____ *ZIP* _____ *Phone ( )* _____

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.

X _____

Signature of Pharmacist or Representative **Date**

	Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
Rx 1	N D C #		Drug Name and Strength	Metric Quantity / Days Supply	Total Charges
Rx 2	Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
	N D C #		Drug Name and Strength	Metric Quantity / Days Supply	Total Charges
Rx 3	Rx #	Date Filled (m/d/y)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
	N D C #		Drug Name and Strength	Metric Quantity / Days Supply	Total Charges

Fraud Prevention Regulation: 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 delay 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:

- Date of purchase
- Drug name
- Drug charge
- Pharmacist's signature and/or original pharmacy receipt(s)
- Prescription number
- Strength
- Quantity
- Pharmacy name
- Computer print-out

DO NOT include charges for durable medical equipment which required a prescription to obtain. No benefits will be provided under this contract for such items.

DO NOT submit cancelled checks or cash register slips. These are not acceptable as substitutes for original receipts.

DO NOT submit statements 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 and group number can be found on your 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.
- Obtain additional claim forms from your company or association and mail directly to the address listed below.
- Please make a copy of all documents and receipts before you send in your claim as no documents will be returned.

PHARMACY INFORMATION

Pharmacy 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, etc., or grams, or mls for liquids, creams, ointments, and injectables.
- Indicate the 'days supply' (the number of days the medication will last).
- Indicate the dollar amount paid by the patient.
- Sign the form.
- Pharmacist questions? Call the Pharmacist help desk at 1-800-364-6331.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC	Drug Ingredient	Quantity	Charge

MAILING INSTRUCTIONS

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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

Blue Cross and Blue Shield of Illinois
P.O. Box 853901
Richardson, Texas 75085-3901