

Prescription Drug Reimbursement Form



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association



See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your BCBS ID card.*

Group No. **B C B S M A N**

Contract/
Enrollee ID #

Enter your 9-digit numeric contract number only; do not include the alpha prefix. The contract number is found on your BCBSM ID card.

Contract/Member Name (First, Last)

Street Address

City

State/Province

Zip/Postal Code

Country

Daytime phone #

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex

Relationship to Plan Member

- | | | |
|--|---|--|
| <input checked="" type="checkbox"/> Female | <input checked="" type="checkbox"/> 1 Self | <input checked="" type="checkbox"/> 5 Disabled Dependent |
| <input checked="" type="checkbox"/> Male | <input checked="" type="checkbox"/> 2 Spouse | <input checked="" type="checkbox"/> 6 Dependent Parent |
| | <input checked="" type="checkbox"/> 3 Eligible Child | <input checked="" type="checkbox"/> 7 Nonspouse Partner |
| | <input checked="" type="checkbox"/> 4 Dependent Student | <input checked="" type="checkbox"/> 8 Other |

Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? Yes No

Acknowledgment (Signature Required for Processing)

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

Date

We have over 50,000 pharmacies in our network. Please ask your pharmacy to bill your services electronically.

Claim Receipts

Tape receipts or itemized bills on the back.
See back for details.

Check the appropriate box if any receipts or bills are for a:

Compound prescription

Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and ingredients and quantities on the receipt or bill.

Medication purchased outside of the United States

Please indicate:

Name of medication and strength

Country

Currency used

Allergy medication

Coordination of Benefits

Please indicate:

Secondary group name

Secondary group number (if present on ID card)

See back for more information

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

**Please tape receipts on the back.
Keep a copy for your records.**



