BlueCross BlueShield of Texas

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company*
HMO Plans **administered by Southwest Texas HMO, Inc*** d/b/a/ HMO Blue® Texas
*Independent Licensees of the Blue Cross and Blue Shield Association

13054
8705.973-403

Prescription Reimbursement Claim Form

Part 1 Member/ Patient Information

Part 1 must be fully completed to ensure proper reimbursement of your drug claim.

Please type or print clearly.

Member ID No. | Group No./Group Name

Member Name | Address

City | State | ZIP | Phone ( )

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

Patient Name | Date of Birth

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

Are any of these medications being taken for an on-the-job injury? ❍ Yes ❍ No

Is the medication covered under any other group insurance? ❍ Yes ❍ No

If yes, is other coverage: ❍ Primary ❍ Secondary If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurer | Policy # | ID # | Phone ( )

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). Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

x

Signature of Cardholder or Legal Representative | **Date**

Part 2 Important.

Please remember to include all original pharmacy receipts.

If you are including all original receipts with the following information, STOP HERE and submit the claim. It is not necessary to complete Part 3. **NOTE:** Do not staple or tape receipts or attachments to this form.

The original receipts should include:

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

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 prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescription(s) 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 cardholder.

x

Signature of Pharmacist or Representative (Required only if original pharmacy receipts are not included) | **Date**

Rx 1

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

Rx 2

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
NDC #	Drug Name and Strength	Metric Quantity	Days Supply	Total Charges

Rx 3

Rx #	Date Filled (mm/dd/yy)	Prescriber's DEA No.	❍ New ❍ Refill ❍ DAW ❍ Compound	For office use only Prior Approval Code
NDC #	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.

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

Obtain additional claim forms from your company or association and mail directly to Blue Cross and Blue Shield of Texas.

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
- Original pharmacy receipts
- Pharmacist's signature (only if original pharmacy receipts are not included)

DO NOT include charges for durable medical equipment that required a prescription to obtain.

DO NOT submit canceled checks, cash register slips or personal itemization. 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 can be found on your ID card.
- The group is the name of your company or association through which you have coverage.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you send them to Blue Cross and Blue Shield of Texas. No documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Indicate pharmacy name, NABP number, address and phone number.
- Include Rx number(s), drug name(s), strength(s) and date filled.
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound.
- Include NDC number(s) for the drug(s) dispensed.
- 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" (the number of days the medication will last).
- Indicate the amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Customer Service: PPO/POS; Traditional: 800-521-2227; HMO's: 877-299-2377.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC #	Drug Ingredient	Quantity	Charge

MAIL THIS FORM TO:

Blue Cross and Blue Shield of Texas / P.O. Box 650204 / Dallas, Texas 75265-0204 / www.bcbstx.com
If you have questions, please contact: Customer Service for PPO/POS, Traditional: 800-521-2227;
for HMO: 877-299-2377
Monday–Friday, 7 a.m.–10 p.m. CT / Saturday, 8 a.m.–8 p.m. CT / Sunday, 8 a.m.–4 p.m. CT
Closed on national holidays