BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

This form should be completed by the physician and/or the physician's staff.

SPECIALTY PHARMACY FORM

Contact Provider Customer Service for additional information.

The telephone number is located on the back of the member's ID card.

Patient Information															
Contract Number	Grou Num				Social Secu Number	urity] – []-[
Last Name	First Name									Middle Initial					
Cardholder's Last Name		First Name							Middle Initial						
Address															
City	State	e	Zip			County									
Day Telephone (+ Area Code)	Night Telepho (+ Area Code)	one				E-mail									
Date of Birth	Sov.						kgs. (or)						lbs.		
Allergies: Yes No If yes, explain:								-	-						
Physician Information															
PMD Prescriber's Name	Hospital/Clinic	C				Office Contact									
Address															
City	State		County												
Office Telephone	Fax Number					E-mail									
Prescriber's License Number	Drug Enforcement Administration (DEA) Num					r									
Is Physician PMD: Yes No			- 1												
Unique Provider Identification Unique Provider Identification	Legacy Number														
Statement of Medical Necessity															
Primary Diagnosis (ICD-9-CM Code Plus Description)* Date of Diagnosis															
Prescription Information															
Drug Name	Dose	Quantity/ Day Supply				SIG/Directions						Refill	s		
Ancillary Supplies As Needed for Infection	on														
Enroll patient in manufacturer support progr	ram 🗌 D)ispense a	s written		Substitut	tion allow	red	Ship	to:	P	atient				
Other Prescriber's Notes:								D	octor	's Offi	се				
*International Classification of Diseases – Ninth Revision (ICD-9)															
I certify this information															
is complete and correct to	Signature					Title					Date		_		