Prescription Drug Reimbursement Form

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



BLUE CROSS

Subscriber Information See your ID card. Prefix Identification Number	Claim Receipts
	Tape claim receipts or itemized bills on the back Do not staple!
Rx Group Number BCWAPDP	Check the appropriate box if any of the receipt are for a medication that:
Member Name (First, Last)	 Is a compound prescription.* Make sure your pharmacist lists ALL the
	VALID 11-digit NDC numbers and quantitie
Street Address	for each ingredient on the back of this form and attach receipts. Claim will be returned
	incomplete.
City State Zip	ONE CLAIM FORM PER COMPOUND PRESCRIPTION.
Patient Information	Was purchased outside the U.S.A. If so, please indicate:
Patient Name (First, Last)	Country
Patient Date of Birth (Month/Day/Year)	Currency used
Gender Relation to Plan Subscriber	Important: Foreign claims MUST include:
□ Female □ 1 Self	1) Name of drug2) Strength
☐ Male ☐ 2 Spouse/Domestic Partner	3) Quantity
☐ 3 Dependent	Claim will be returned if incomplete.
Pharmacy Information	☐ Is for treatment of an allergy.
	Secondary Prescription Claims
Name of Pharmacy	Medicare supplement members need not complete this section.
Street Address	 Submitting claim for secondary prescription reimbursement.
	Check one:
City State Zip	☐ Receipt indicates the total price paid for the prescription.
Telephone (include area code)	☐ Receipt indicates the copayment amount paid under primary plan or other health insurance carrier.
	 Explanation of Benefits from primary pla or other health insurance carrier attached
	For secondary claim submission only
A A CONTRACTOR OF THE CONTRACT	Return the completed form and receipt(s) to:
* A compounded medicine is a blend of ingredients that the pharmacist prepares especially for you at your prescriber's request. To be covered under your	Premera Blue Cross
pharmacy benefit, a compounded medicine must have at least one ingredient	PO Box 91059, Seattle, WA 98111-9159
that is a prescription drug with an FDA-approved therapeutic indication.	Please tape receipts on the back
Acknowledgment	
I certify that the medication(s) described above was/were received for use by the patimyself) am eligible for drug benefits. I also certify that the medication received was not benefit plan. I recognize that reimbursement will be paid directly to me, and that assiparty is void.	ot for an on-the-job injury or covered under another
X	Date / /
Λ	Pale / /

Claim Receipts

Please tape your receipts here. **Do not staple!** Tape additional non-compound receipts on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#		Date Filled		Days Supply	
VALID 11-digit NDC#			Quantity		
			Tatal Occupits		
ions			Total Quantity Total Charge		

Direct Reimbursement Claim Instructions Read carefully before completing this form.

- 1. Always present your ID card at the participating retail pharmacy.
- 2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because:
 - the pharmacy does not accept your ID card.
 - you have not received your ID card.
- 3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient**.
- 4. You must submit claims within one year of date of purchase or as required by your Plan.

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.

Questions? Call the Premera Blue Cross Customer Service number listed on the back of your ID card or visit www.premera.com.

- 5. Be sure your receipts are complete. In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
- 6. You should read the Acknowledgment carefully, then sign and date this form.
- 7. Return the completed form and receipt(s) to:

Medco Health Solutions, Inc. P.O. Box 14711 Lexington, KY 40512

Note: See front of form for Secondary Prescription claims address.



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