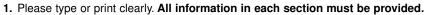


BlueCross BlueShield of Massachusetts

DRUG CLAIM FORM



- 2. All forms must be accompanied by an original prescription receipts.
- 3. A separate form must be completed for each patient.
- 4. Please tape additional prescriptions on a separate piece of paper.
- **5.** If you need assistance completing this form, please contact Member Services at the number listed on the front of your card.

Incomplete information will result in payment delays and returned forms.

Express Scripts USE ONLY	
Express Scripts USE UNLI	

EMPLOYEE / RETIREE INFORMATION	PATIENT INFORMATION
Subscriber ID number Last Name Date of Birth – MMD First Name Daytime Phone Street Address City State Zip Code	Patient Last Name
PHARMACY INFORMATION	OTHER INFORMATION
Pharmacy Name: Address: State: Phone: Phone: Phone: Phone: State: State: Phone:	Does the patient have primary prescription drug coverage through another insurance carrier? Did the patient submit this claim to the other coverage? If yes, please attach an explanation of benefits from your primary insurance carrier. Does this patient reside in a nursing home? Yes No Is this claim for allergy serum?
Prescription Information Receipt #1	Tape Prescription Receipt #1 Here – No Staples
Complete information below if not found on receipt #1 National Drug Code	The receipt(s) must contain the following information: 1. Rx # 2. Date prescription filled 3. Quantity 4. Days Supply 5. National Drug Code (NDC) 6. Name of drug and strength 7. DAW code (if applicable) 8. Amount paid
Prescription Information Receipt #2	Tape Prescription Receipt #2 Here – No Staples
Complete information below if not found on receipt #2 National Drug Code	The receipt(s) must contain the following information: 1. Rx # 2. Date prescription filled 3. Quantity 4. Days Supply 5. National Drug Code (NDC) 6. Name of drug and strength 7. DAW code (if applicable) 8. Amount paid

Any intentional false statement or alteration of this claim form is a crime under the laws of the commonwealth punishable by fine, imprisonment or both.

To the best of my knowledge the above information is correct and that the patient named is eligible for benefits.

Mail Completed Form To:

Express Scripts/BCBS-MA Attn: Member Reimbursement P.O. Box 66773 St. Louis, MO 63166-6773

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