BlueCross BlueShield of Illinois

PRESCRIPTION DRUG CARD REIMBURSEMENT CLAIM FORM

PLEASE TYPE OR PRINT CLEARLY.

Not to be used for BlueSCRIPT reimbursement.

PART 1: MEMBER INFORMATION Must be fully completed for reimbursement of your drug claim.

Member ID number _____ Group number _____ PCN number (bottom face of ID card) **IL** _____

Member name _____ Member phone _____

Address _____ City _____ State _____ Zip _____

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

Patient name _____ Social Security No._____ Date of birth _____

Relationship: ❒ Member ❒ Spouse ❒ Child ❒ Other _____ Patient: ❒ Male ❒ Female

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 number _____ ID number _____ Phone _____

I certify that all the information entered on this form is correct. In addition, I also 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).

X_____ _____

Signature of Patient or Legal Representative — Date

PART 2: IMPORTANT Please remember to include all **original** pharmacy receipts.

Receipts must include:

- ■ Pharmacy name
- ■ Prescription number
- ■ Drug name
- ■ Quantity
- ■ NDC number
- ■ Strength
- ■ Date purchased
- ■ Drug charge
- ■ Days supply

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 prescriptions, please enter COMPOUND RX in the space designated for the NDC number and complete the compound section on the reverse side.

Pharmacy name _____ Pharmacy NABP number _____

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 member.

X_____ _____

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

Rx 1

Rx number | Date filled (mo/dy/year) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only)

NDC number | Drug name and strength | Metric quantity | Days supply | Total charge

Rx 2

Rx number | Date filled (mo/dy/year) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only)

NDC number | Drug name and strength | Metric quantity | Days supply | Total charge

Rx 3

Rx number | Date filled (mo/dy/year) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only)

NDC number | Drug name and strength | Metric quantity | Days supply | Total charge

Fraud Prevention: 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.

IT IS TO YOUR ADVANTAGE TO ALWAYS USE YOUR PRESCRIPTION DRUG CARD TO AVOID FILING PAPER CLAIMS, WHICH DELAYS PAYMENT OF YOUR BENEFITS. Reminder: DO NOT use this form for BlueSCRIPT reimbursement.

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, if original receipt(s) is not attached

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
- Computer print-out
- Pharmacist's signature and/or original pharmacy receipt(s)

- DO NOT include charges for durable medical equipment which required a prescription to obtain.
- DO NOT submit canceled checks or cash register slips. These are not acceptable as substitutes for original receipts.
- DO NOT submit statement 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, group number and PCN number can be found on your member ID card.
- Sign and date in the space provided. Your signature certifies that the information is correct and complete.
- Complete a separate form for each family member and for each pharmacy.
- See your benefit administrator for additional claim forms, or log on to our Web site at www.bcbsil.com to download additional forms. Mail your completed form to the address shown below.
- Please make a copy of all documents and receipts before you send in your claim(s) as no documents will be returned.

PHARMACY INFORMATION

Pharmacist to complete Part 3 of the form

- Include Rx number(s), drug name(s), strength(s) and date filled.
- Include NDC number(s) for the drug(s) dispensed.
- Indicate NABP number, pharmacy address and phone number.
- 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 (number of days the medication will last).
- Indicate the amount paid by the patient.
- Sign and date the form.
- Pharmacist questions? Call Prime Therapeutics' Contact Center at **800.821.4795.**

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC number	Drug ingredient	Quantity	Charge

MAILING INSTRUCTIONS

Mail this form and your original paid pharmacy receipt(s) to:

Blue Cross and Blue Shield of Illinois
P.O. Box 64812
St. Paul, MN 55164-0812