

Prescription Drug Claim Form



BlueCross BlueShield
of Illinois

See instructions on reverse.

Patient Information

ID Number

Group Number -

Date of Birth / / Male Female

Patient Name (First, Last) _____

Street Address _____

City _____ State _____ ZIP _____

Patient's Relationship to Subscriber/Member:

Self Spouse Dependent

I certify that the information is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein and authorize release of all information contained on this claim form to Prime Therapeutics. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

I understand that Blue Cross and Blue Shield of Illinois use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical or pharmacy 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.

Patient/Subscriber/Member or Legal Representative Signature _____

Is this medication for an on-the-job-injury? Yes No

Policy Number: _____

Please include any pharmacy receipts related to this claim with this form.

Subscriber/Member Information

Name (First, Last) _____

Pharmacy Information

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ ZIP _____

Prescription Claim Information

Original pharmacy receipts are required. Please attach receipts to space provided on the back of form. If receipts are not included, please have pharmacist complete and sign the bottom of this form.

Was this prescription medication purchased outside the U.S.A.? Yes No

All fields below must be completed.
(Example on back of form.)

Call your pharmacist if you need assistance.

1 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number
(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost \$.

Balance Due \$.

2 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number
(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost \$.

Balance Due \$.

3 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number
(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost \$.

Balance Due \$.

X

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

Date _____

Pharmacy/Prescription Information

- Use a **separate claim form** for each patient. All information provided on or attached to this claim form must be for the same patient.
- Tape or glue pharmacy receipts in the spaces provided. When you tape or glue your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the taped or glued receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:

- Patient Name
- Pharmacy Name/Address
- Total Charge
- Drug Name and NDC Number
- NPI Number
- Quantity
- Fill Date
- Rx Number
- Days Supply

If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing information.

Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.

- Call the customer service number on your ID card if you have any questions.
- Have your pharmacist call 800.821.4795 if he/she has any questions.
- Send completed form to:

Prime Therapeutics
P.O. Box 14624
Lexington, KY 40512-4624

Rx 1	Rx 2																												
<p style="text-align: center;">EXAMPLE of how to complete the Prescription Drug Claim Form.</p> <p>1 Rx Number <input type="text" value="0"/><input type="text" value="0"/><input type="text" value="0"/><input type="text" value="0"/><input type="text" value="0"/><input type="text" value="6"/><input type="text" value="0"/><input type="text" value="1"/><input type="text" value="1"/><input type="text" value="4"/><input type="text" value="8"/><input type="text" value="1"/></p> <p>Date Filled <input type="text" value="0"/><input type="text" value="1"/> / <input type="text" value="1"/><input type="text" value="2"/> / <input type="text" value="0"/><input type="text" value="5"/></p> <p>Quantity <input type="text" value="30"/> Day Supply <input type="text" value="3"/><input type="text" value="0"/></p> <p>Name of Medication <u>"Drug Name"</u></p> <p>NDC Number <input type="text" value="0"/><input type="text" value="0"/><input type="text" value="1"/><input type="text" value="2"/><input type="text" value="3"/><input type="text" value="4"/><input type="text" value="5"/><input type="text" value="6"/><input type="text" value="7"/><input type="text" value="3"/><input type="text" value="1"/> <small>(Your pharmacist can provide the NDC number identifying the drug.)</small></p> <p>NPI Number <input type="text" value="9"/><input type="text" value="2"/><input type="text" value="1"/><input type="text" value="5"/><input type="text" value="2"/><input type="text" value="4"/><input type="text" value="1"/><input type="text" value="1"/><input type="text" value="6"/><input type="text" value="3"/></p> <p>Prescription Cost \$ <input type="text" value="2"/><input type="text" value="0"/><input type="text" value="5"/> . <input type="text" value="1"/><input type="text" value="4"/></p> <p>Balance Due \$ <input type="text" value="2"/><input type="text" value="0"/><input type="text" value="5"/> . <input type="text" value="1"/><input type="text" value="4"/></p>	<p>Is this prescription claim for a compound medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note: If yes, make sure your pharmacist completes the information below.</p> <p>Compound Information: If a compound prescription, please enter all information per drug used.</p> <p style="text-align: center;">Compound Prescriptions For pharmacy use only</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">NDC Number</th> <th style="width: 40%;">Drug Ingredient</th> <th style="width: 15%;">Quantity</th> <th style="width: 30%;">Charge</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	NDC Number	Drug Ingredient	Quantity	Charge																								
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Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan 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.

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