

Prescription Drug Claim Form



Member information (See other side for instructions)

ID number

Group number

Date of birth / / Male Female

Name (First, Last) _____

Street address _____

City _____ State _____ Zip _____

Member's relationship to primary cardholder:
 Self Spouse/Domestic partner Dependent/Child

I certify that:
• The information on this form is correct
• The member named above is eligible for pharmacy benefits
• The member named above received the drug(s) listed
• I give my permission to share the information on this form with Capital BlueCross' pharmacy benefits manager

X _____
Member or legal representative signature

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

Do you have other insurance for this prescription drug? Yes No

If yes, what is the other insurance company's name? _____

Cardholder information (primary cardholder)

Name (First, Last) _____

Why are you submitting this Prescription Drug Claim Form? (check one)

- Did not have my pharmacy card with me when I bought this prescription
- Have not received my pharmacy card
- Picked up my drug from a non-network pharmacy
- My other insurance is paying for part of this drug (attach that company's Explanation of Benefits and an itemized receipt)
- Other (please explain) _____

Pharmacy information

Pharmacy name _____

Pharmacy address _____

City _____ State _____ Zip _____

Pharmacy NPI number

Prescription (Rx) claim information

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

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form. Cash register receipts will not be accepted.

1 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Prescription cost \$.

Balance due \$.

2 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Prescription cost \$.

Balance due \$.

Instructions

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

Questions?

- Call the number on the back of your member ID card
3. Send this completed form with itemized receipts to:
Pharmacy Services
PO Box 25137
Lehigh Valley, PA 18002-5137

EXAMPLE

Rx number

Date filled / /

Quantity Days' supply

Name of medicine "Drug Name"

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Total prescription charge \$.

Is this prescription claim for a compound medicine?

Yes No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

Rx 2

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

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 health plan act, which is a crime and subjects such person to criminal and civil penalties.

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