

Prescription Reimbursement Claim Form

Important!



- Always allow up to 30 days from the time you receive the response to allow for claims processing and delivery.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1

Card Holder/Patient Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name

MI

Address

Address 2

City

State

ZIP Code

Country

Patient Information—Use a separate claim form for each patient

Last Name

First Name

MI

Date of Birth

Male

Female

Phone Number

Relationship to Primary Member

Member Spouse Child Other

Pharmacy Information

Pharmacy Name

Address

City

State

ZIP Code

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)

Reason I am filing this form is:

- Allergy/Allergen Clinic
- Pharmacy does not accept insurance
- Compound
- No insurance coverage at the time
- Other—provide reason below

Medication purchased outside of the United States (Tape receipts and/or itemized bills on another sheet of paper)

PLEASE INDICATE:

Country: _____

Currency used: _____

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? YES NO

Is the medicine covered under any other group insurance? YES NO

If YES, is other coverage:

- PRIMARY SECONDARY
- MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

ID#: _____

Pharmacy Information (Cont.)

Phone Number

Is this an on-site nursing home pharmacy?

YES

NO

NCPDP/NPI Required

X

Signature of Pharmacist or Representative

Important! A signature is REQUIRED

NOTICE

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, denial of benefits and/or imprisonment.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X

Signature of Patient (REQUIRED)

Date

STEP 2 Submission Requirements

You **MUST** include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will **ONLY** be accepted for diabetes supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Patient Name
- Prescription Number
- Medicine NDC Number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NCPDP Number

Number of prescriptions you are submitting for reimbursement: _____

Prescribing physician's national provider identification (NPI) number (required): _____

Prescribing physician's information (all fields required):

Name: _____

Address: _____

City, State, ZIP Code: _____

Phone: _____

Additional comments: _____

STEP 3 Mail completed forms with receipts to:

Blue Shield of California
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your ID card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your ID card.

Prescription Claim Information

Prescription 1	Prescription (Rx) Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Drug Name	
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Prescription 2	Prescription (Rx) Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Drug Name	
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Allergy Claim Information

Allergy 1	Date of Purchase (MM/DD/YY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of Vials <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Charge per treatment for professional immunotherapy in your office. (\$ Amount) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Number of Treatments <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Single Dose <input type="checkbox"/> Multidose	Days Supply <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Charge for preparation of allergenic extract in location other than your office. (\$ Amount) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Vial Contains <input type="checkbox"/> Single Antigen <input type="checkbox"/> Multiantigen	Administered By <input type="checkbox"/> Physician <input type="checkbox"/> Nurse <input type="checkbox"/> Self	Total charge for allergenic extract only. (\$ Amount) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Directions		
Ingredients			
Allergy 2	Date of Purchase (MM/DD/YY) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Number of Vials <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Charge per treatment for professional immunotherapy in your office. (\$ Amount) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Number of Treatments <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Single Dose <input type="checkbox"/> Multidose	Days Supply <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Charge for preparation of allergenic extract in location other than your office. (\$ Amount) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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