MEDICARE PRESCRIPTION DRUG CLAIM FORM

See claim form on reverse.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

INSTRUCTIONS

- To process your claim(s) in the most timely manner, you must provide all information requested.
- Contact your pharmacist, if necessary, to provide the detailed drug information requested. Prescription receipts or a pharmacy-generated drug summary must be attached. Cash register receipts are not acceptable.
- Use your member ID card to obtain your identification number.
- A separate claim form must be used for each patient and pharmacy.
- If you are submitting more than two prescription claims, please use a new claim form. All fields must be completed for each submitted prescription.

Example of how to complete the Prescription Drug Claim Form.

1 Rx Number 6 0 1 1 4 8 1

Date Filled 1 0 / 0 1 / 2 0 0 7

Quantity 90 Days Supply

Name of Medication ABC DRUG

NDC Number 0 0 1 8 6 5 0 2 2 2 8

Prescription Cost $ 1 4 6 . 0 4

Balance Due $.

- If additional claim forms are needed, call customer service at the number listed on the back of your member ID card.
- Mail completed claim form along with prescription receipts to:

BlueMedicare
P.O. Box 64813
St. Paul, MN 55164

If you need information or help, call us at: Toll Free: 1-800-926-6565 TTY/TDD: 711 daily, 8 a.m. to 9 p.m. ET. Other resources to help you: 1-800-MEDICARE (1-800-633-4227) TTY/TDD: 1-877-486-2048, available 24 hours/day, 7 days/week.

CLAIM SUBMISSION

- DO NOT include charges for durable medical equipment.
- DO NOT submit canceled checks or cash register slips. These are not acceptable as substitutes for original receipts.
- DO NOT submit statements with balance amounts only.

HOW TO COMPLETE THIS FORM

- The ID number and group number can be found on your 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 pharmacy.
- 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.

COMPOUND INFORMATION

- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used.

COMPOUND PRESCRIPTIONS
For pharmacy use only

NDC number	Drug Ingredient	Quantity	Charge

Health Care Fraud Notice–Health care fraud affects us all and causes an increase in health care costs. If you know or suspect any type of health care insurance fraud, please call us at the fraud hotline, 1-800-678-8355 TTY/TDD: 711 daily, 8 a.m. to 9 p.m. ET. All calls are confidential and you may report your concerns anonymously via our toll free hotline.

H1026_22322 1007R S: 10/2007
H5434_22322 1007R S: 10/2007
S5904_22322 1007R S: 10/2007
H3518_22322 1007 S: 10/2007

H1026_22322 1007R EGWP S: 10/2007
H5434_22322 1007R EGWP S: 10/2007
S5904_22322 1007R EGWP S: 10/2007
H3518_22322 1007 EGWP S: 10/2007

MEDICARE PRESCRIPTION DRUG CLAIM FORM

SUBSCRIBER INFORMATION

Group Number ☐☐☐☐☐☐☐

Identification (ID) Number ☐☐☐☐☐☐☐☐☐☐☐☐

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

❑ Male ❑ Female

Subscriber Name (First, Last)

Street Address

City State ZIP

I certify that the information is correct and that the patient indicated below is eligible for benefits. I have received the medications described hereon 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.

Patient/Subscriber Signature

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

Related to Auto Accident . . . . . ❑ Yes ❑ No

Do you have other insurance for prescription medications? . . . . . ❑ Yes ❑ No

If yes, please provide

Name of Insurance Company

Was an out-of-network pharmacy used? . . . . . ❑ Yes ❑ No

If yes, provide reason below:

❑ Traveling within the US, but outside of Plan's service area, and became ill, or lost or ran out of your prescription drugs.

❑ Unable to obtain a covered drug in a timely manner–there were no network pharmacies within a reasonable driving distance that provide 24/7 service.

❑ Trying to fill a covered drug that is not regularly stocked at a network retail or mail order pharmacy (i.e., orphan drugs or specialty pharmaceuticals).

❑ Was a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

PHARMACY INFORMATION

Pharmacy Name

Pharmacy Address

City State ZIP

PRESCRIPTION CLAIM INFORMATION

Original pharmacy receipts are required. Do not staple.

Is this prescription claim for a compound medication? . . . . . ❑ Yes ❑ No

Note: If yes, make sure your pharmacist lists the NDC number for the active ingredient.

Receipts must include:

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

All fields below must be completed. Call your pharmacist if you need assistance.

1 Rx Number ☐☐☐☐☐☐☐

Date Filled ☐☐ / ☐☐ / ☐☐☐☐

Quantity _____ Days Supply

Name of Medication _____

NDC Number ☐☐☐☐☐☐☐☐☐☐☐

Prescription Cost $ ☐☐☐☐ . ☐☐

Balance Due $ ☐☐☐☐ . ☐☐

2 Rx Number ☐☐☐☐☐☐☐

Date Filled ☐☐ / ☐☐ / ☐☐☐☐

Quantity _____ Days Supply

Name of Medication _____

NDC Number ☐☐☐☐☐☐☐☐☐☐☐

Prescription Cost $ ☐☐☐☐ . ☐☐

Balance Due $ ☐☐☐☐ . ☐☐

Reset