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

MediScript Prescription Program Claim

I. MEMBER INFORMATION

This section must be filled out in its entirety for claims to be processed. The Contract Number can be found on the member's Blue Cross and Blue Shield Florida ID Card.

MEMBER NAME (LAST, FIRST, MI)	ID NO. H	DATE OF BIRTH (MO, DAY, YR)
GROUP NUMBER		
ADDRESS (Complete only if address has changed)		SEX ☐ MALE ☐ FEMALE
CITY, STATE, ZIP CODE		

II. PATIENT INFORMATION (Must be completed if patient is a dependent child or spouse)

This section must be filled out in its entirety for dependent claims to be processed.

PATIENT NAME (LAST, FIRST, MI)	DATE OF BIRTH (MO, DAY, YR)	
ADDRESS (If different than member)	SEX ☐ MALE ☐ FEMALE	RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ DISABLED DEPENDENT CHILD
CITY, STATE, ZIP CODE		

III. GENERAL INFORMATION

This section must be filled out in its entirety for claims resulting from an accident or claims submitted with other insurance.
Attach a copy of the Explanation of Benefits and payment, if applicable.

A. Was condition related to an accident? ☐ **Y**es ☐ **N**o Accident Date ___/___/___

If yes, was it related to: ☐ **A**uto Accident ☐ **W**orkers' Comp ☐ **O**ther _____

B. Is other insurance applicable to charge? ☐ YES ☐ NO

If yes, complete the information below. You must submit an EOB for your claim to be processed.

Other Carrier Name _____ Policy # _____

Name of Subscriber _____ Amount Paid By Other Insurance $ _____

IV. CERTIFICATION AND AUTHORIZATION

The Member/Patient must sign the Certification section.

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge.

MEMBER/PATIENT SIGNATURE	DATE

Reset

V. PHARMACY/PRESCRIPTION INFORMATION

1. Use a separate claim form for each patient. All information provided on or attached to this claim form must be for the same patient.
2. Tape or glue pharmacy receipts in the spaces provided or staple your receipts to the top of this form. If 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 • Quantity • Pharmacy Address
   • Purchase Date • Total Charge • Rx#
   • Drug Name and NDC# • Pharmacy Name • Days Supply

   If any of your receipts do not have complete information, ask your pharmacist to provide you with the missing information. Write that information on your receipt(s).
3. Call the customer service number on your ID card if you have any questions.
4. Have your pharmacist call 1-800-821-4795 if he/she has any questions.
5. Send this completed form to:

   Blue Cross and Blue Shield of Florida, Inc.
   Prime Therapeutics
   MediScript Prescription Program
   P.O. Box 14430
   Lexington, KY 40512-4430

Rx 1	Rx 2
PHARMACY RECEIPTS ONLY TAPE OR GLUE ONE PHARMACY RECEIPT IN THIS SPACE. IF YOU PREFER, STAPLE YOUR RECEIPTS TO THE TOP OF THIS FORM. KEEP A COPY OF YOUR RECEIPT(S) FOR YOUR RECORDS.	**PHARMACY RECEIPTS ONLY** TAPE OR GLUE ONE PHARMACY RECEIPT IN THIS SPACE. IF YOU PREFER, STAPLE YOUR RECEIPTS TO THE TOP OF THIS FORM. KEEP A COPY OF YOUR RECEIPT(S) FOR YOUR RECORDS.
Rx 3	**Rx 4**
PHARMACY RECEIPTS ONLY TAPE OR GLUE ONE PHARMACY RECEIPT IN THIS SPACE. IF YOU PREFER, STAPLE YOUR RECEIPTS TO THE TOP OF THIS FORM. KEEP A COPY OF YOUR RECEIPT(S) FOR YOUR RECORDS.	**PHARMACY RECEIPTS ONLY** TAPE OR GLUE ONE PHARMACY RECEIPT IN THIS SPACE. IF YOU PREFER, STAPLE YOUR RECEIPTS TO THE TOP OF THIS FORM. KEEP A COPY OF YOUR RECEIPT(S) FOR YOUR RECORDS.