BlueCross BlueShield Minnesota

PRESCRIPTION DRUG CLAIM

CONTRACT HOLDER

Contract Number	Last Name First Name Middle Initial	Home Telephone Number ( )	Work Telephone Number (furnish only if we may call) ( )
Street Address		City	State / ZIP Code
Does Contract Holder have other insurance covering the Patient? ☐ NO ☐ YES	If ***YES***, name of other insurance company	Other Coverage Effective Date	Please attach a copy of the other insurer's benefit payment notice. / Other Insurance Contract No.
Address of Insurance Company		City	State / ZIP Code

I certify all information provided on this form to be true and correct to the best of my knowledge. SIGNED _____ Signature of Contract Holder _____ Date Signed

PATIENT INFORMATION

Last Name First Name Middle Initial	Date of Birth	Sex ☐ M ☐ F	Relationship to Contract Holder ☐ **Self** ☐ **Child** ☐ **Spouse** ☐ **Other** (explain)
Does Patient have other insurance coverage that ***differs*** from Contract Holder's other coverage, if any? ☐ NO ☐ YES	If ***YES***, name of other insurance company	Other Coverage Effective Date	Please attach a copy of the other insurer's benefit payment notice. / Other Insurance Contract No.

Other Insurance Company Address	City	State	ZIP Code	Was condition related to:	NO	YES
				Patient's employment?	☐	☐
				Accident?	☐	☐

PRESCRIPTION DRUGS

- Please use a separate form for each pharmacy and each patient.
- Complete ***ALL*** items below. In most cases, information requested will be on the pharmacy receipt. Ask your pharmacist for the information if it is not on the receipt.
- Attach original receipt ***OR*** have the pharmacist sign this form below.

	Prescription Number (Rx #)	Date Filled	Amount Charged	Quantity	Days Supply	Diagnosis
1.						
	National Drug Code (NDC)	Drug Name, Strength, Form	Manufacturer			
	Prescribing Physician's Name	Physician's Street Address	City	State	Zip	Physician's Telephone Number ( )
2.	Prescription Number (Rx #)	Date Filled	Amount Charged	Quantity	Days Supply	Diagnosis
	National Drug Code (NDC)	Drug Name, Strength, Form	Manufacturer			
	Prescribing Physician's Name	Physician's Street Address	City	State	Zip	Physician's Telephone Number ( )
3.	Prescription Number (Rx #)	Date Filled	Amount Charged	Quantity	Days Supply	Diagnosis
	National Drug Code (NDC)	Drug Name, Strength, Form	Manufacturer			
	Prescribing Physician's Name	Physician's Street Address	City	State	Zip	Physician's Telephone Number ( )
4.	Prescription Number (Rx #)	Date Filled	Amount Charged	Quantity	Days Supply	Diagnosis
	National Drug Code (NDC)	Drug Name, Strength, Form	Manufacturer			
	Prescribing Physician's Name	Physician's Street Address	City	State	Zip	Physician's Telephone Number ( )

PHARMACY INFORMATION

Pharmacy Name	Pharmacy/NABP Number	Telephone Number
Street Address	City	State / ZIP Code

I certify that the prescriptions listed above are legend drugs which require a prescription and must be dispensed by a Registered Pharmacist. I further certify that they were ordered by the Patient's attending Physician for his/her use. _____ Signature of Registered Pharmacist _____ Date Signed

Filing Your Claim is Easy if you Follow These Instructions:

- Use a **separate** claim form for each family member and each pharmacy.
- Complete the **top** portion — Patient Information and Contract Holder Information completely. We prefer that you use black ink.
- Make sure the Contract Holder signs this form in the Contract Holder's certification space.
- You may need help from your pharmacist in completing the lower portion of this claim from regarding specific information about the prescription(s). Often, items such as the NDC Number, Manufacturer, Drug Name, Strength, Form,Quantity and Days Supply will be on the pharmacy receipt. Your pharmacist will be able to tell you how to determine the information that is abbreviated. If the information is not on the pharmacy receipt, ask the pharmacist for it.
- Attach original pharmacy receipts for each prescription that include the following information:

  — Date of Purchase
  — Prescription Number
  — Charge
  — Patient's Name
  — Name, Address and Phone Number of Pharmacy
  — Name and Address of Prescribing Physician
  — Drug Name and NDC Number

- If you attach the original pharmacy receipts you **do not** have to have the **pharmacist's signature**.
- Mail this claim form to the address shown below:

Birmingham Service Center
ATTENTION: Prescription Drug Benefit
PO Box 10527
Birmingham, AL 35202-0500