Prescription Drug Claim Form

See instructions on reverse.

BlueCross BlueShield of Illinois

Patient Information

ID Number

Group Number

Date of Birth / / ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

I certify that all the information on this form is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein 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.

I understand that Blue Cross and Blue Shield of Illinois use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical or pharmacy providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996). Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Patient/Subscriber/Member or Legal Representative Signature

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

Please include any pharmacy receipts related to this claim with this form.

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

Original pharmacy receipts are required. Please attach receipts to space provided on the back of form. If receipts are not included, please have pharmacist complete and sign the bottom of this form.

Was this prescription medication purchased outside the U.S.A.? . . . . . ❑ Yes ❑ No

All fields below must be completed. (Example on back of form.) Call your pharmacist if you need assistance.

1 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Total Charge $.

2 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Total Charge $.

3 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Total Charge $.

X _____ _____

Signature of Pharmacist or Representative (Required only if original pharmacy receipts are not included) Date

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. Attach pharmacy receipts in the spaces provided. When you attach your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:
   - Patient Name
   - Pharmacy Name/Address
   - Total Charge
   - Drug Name and NDC#
   - Quantity
   - Fill Date
   - Rx#
   - Days Supply

   If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing information. Write that information on your receipt(s). If not completed, the claim will be sent back for the required information. Pharmacist will need to complete and sign the opposite side of this form if original receipts do not include all necessary information.
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 completed form and original receipts to:

   Prime Therapeutics
   P.O. Box 14624
   Lexington, KY 40512-4624

EXAMPLE

of how to complete the Prescription Drug Claim Form.

1 Rx Number 6 0 1 1 4 8 1

Date Filled 0 1 / 1 2 / 0 5

Quantity 30 Day Supply 3 0

Name of Medication "Drug Name"

NDC Number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the NDC number identifying the drug.)

Total Charge $ 2 0 5 . 1 4

Rx 1

Pharmacy Receipts Only

Attach 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 2

Pharmacy Receipts Only

Attach 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

Pharmacy Receipts Only

Attach 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.

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

Blue Cross and Blue Shield of Illinois is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.