

# Prescription Drug Claim Form

See instructions on reverse.



## Patient Information

Member ID

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 the information 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.

Patient/Subscriber/Member or Legal Representative Signature \_\_\_\_\_

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

Do you have other insurance for prescription medications?  Yes  No

If yes, please provide Name of other Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_

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

## 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.)

NPI Number

Prescription Cost \$  .

Balance Due \$  .

2 Rx Number

Date Filled  /  /

Quantity \_\_\_\_\_ Day Supply

Name of Medication \_\_\_\_\_

NDC Number

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

NPI Number

Prescription Cost \$  .

Balance Due \$  .

3 Rx Number

Date Filled  /  /

Quantity \_\_\_\_\_ Day Supply

Name of Medication \_\_\_\_\_

NDC Number

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

NPI Number

Prescription Cost \$  .

Balance Due \$  .

**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.  
When 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
- Pharmacy Name/Address
- Total Charge
- Drug Name and NDC Number
- NPI Number
- Quantity
- Fill Date
- Rx Number
- 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.

3. Call the customer service number on your ID card if you have any questions.
4. Have your pharmacist call 888.274.5186 if he/she has any questions.
5. Send completed form to:

Prime Therapeutics  
Mail Route BCBSNC  
P.O. Box 14501  
Lexington, KY 40512-4501

Rx 1	Rx 2																								
<p style="text-align: center;"><b>EXAMPLE</b> of how to complete the Prescription Drug Claim Form.</p> <p><b>1</b> Rx Number <input style="width: 150px;" type="text" value="000006011481"/></p> <p>Date Filled <input style="width: 100px;" type="text" value="01/12/12"/></p> <p>Quantity <input style="width: 50px;" type="text" value="30"/> Day Supply <input style="width: 50px;" type="text" value="30"/></p> <p>Name of Medication <input style="width: 200px;" type="text" value="Drug Name"/></p> <p>NDC Number <input style="width: 150px;" type="text" value="00123456731"/> <small>(Your pharmacist can provide the NDC number identifying the drug.)</small></p> <p>NPI Number <input style="width: 150px;" type="text" value="9215241163"/></p> <p>Prescription Cost \$ <input style="width: 50px;" type="text" value="205"/> . <input style="width: 50px;" type="text" value="14"/></p> <p>Balance Due \$ <input style="width: 50px;" type="text" value="50"/> . <input style="width: 50px;" type="text" value="00"/></p>	<p>Is this prescription claim for a compound medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Note: If yes, make sure your pharmacist completes the information below.</p> <p><b>Compound Information:</b> If a compound prescription, please enter all information per drug used.</p> <p style="text-align: center;"><b>Compound Prescriptions</b> For pharmacy use only</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">NDC Number</th> <th style="width: 45%;">Drug Ingredient</th> <th style="width: 15%;">Quantity</th> <th style="width: 25%;">Charge</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	NDC Number	Drug Ingredient	Quantity	Charge																				
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