Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

PREMERA | BLUE CROSS

Subscriber Information *See your ID card.*

Prefix ☐☐☐ Identification Number ☐☐☐☐☐☐☐☐☐

Rx Group Number **BCWAPDP**

Member Name (First, Last)

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Gender
☐ Female
☐ Male

Relation to Plan Subscriber
☐ 1 Self
☐ 2 Spouse/Domestic Partner
☐ 3 Dependent

Pharmacy Information

Name of Pharmacy

Street Address

City State ☐☐ Zip ☐☐☐☐☐

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐No

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act, which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment or denial of benefits.†

***** A compounded medicine is a blend of ingredients that the pharmacist prepares especially for you at your prescriber's request. To be covered under your pharmacy benefit, a compounded medicine must have at least one ingredient that is a prescription drug with an FDA-approved therapeutic indication.

Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

☐ **Is a compound prescription.***
Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND PRESCRIPTION.

☐ **Was purchased outside the U.S.A.**
If so, please indicate:

Country _____

Currency used _____

Important: Foreign claims MUST include:

1) Name of drug
2) Strength
3) Quantity

Claim will be returned if incomplete.

☐ **Is for treatment of an allergy.**

Other Prescription Drug Coverage

Medicare supplement members need not complete this section.

☐ **Submitting claim for secondary prescription reimbursement.**

Check one:

☐ Receipt indicates the total price paid for the prescription.

☐ Receipt indicates the copayment amount paid under primary plan or other health insurance carrier.

☐ Explanation of Benefits from primary plan or other health insurance carrier attached.

For secondary claim submission only

Return the completed form and receipt(s) to:

Premera Blue Cross
PO Box 91059, Seattle, WA 98111-9159

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____ **Date** ____ / ____ / ____

Signature of Patient (or legal guardian if patient cannot legally consent to services)

If allowed by law, you may assign the payment of this claim to your pharmacy. If your pharmacy is willing to accept assignment, do not complete this form. Please request that your pharmacy contact Pharmacy Services at 1 800 922-1557 for assistance.

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Claim Receipts

Please tape your receipts here. **Do not staple!** Tape additional non-compound receipts on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- For each NDC number, indicate cost per ingredient.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX #		Date filled		Days' supply	

VALID 11-digit NDC #	Quantity	Price
Total quantity		
Total charge		

Direct Reimbursement Claim Instructions

Read carefully before completing this form.

1. Always present your ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because you:
   - have not received your ID card.
   - did not have your ID card at the time of purchase.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within one year of date of purchase or as required by your Plan.
5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
6. You should read the Acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipt(s) to:

Express Scripts
P.O. Box 14711
Lexington, KY 40512

Note: *See front of form for Secondary Prescription claims address.*

†California: For your protection, California law requires the following to appear on this form: 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.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company 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.

Questions? Call the Premera Blue Cross Customer Service number listed on the back of your ID card or visit *www.premera.com*.

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