# PRESCRIPTION REIMBURSEMENT CLAIM FORM

BlueCross BlueShield of Texas†

**Please type or print clearly.**

**PART 1: MEMBER/PATIENT INFORMATION.** Must be fully completed to ensure proper reimbursement of your drug claim.

Member ID number _____ Group number/group name _____

Member name _____ Member phone _____

Address _____ City _____ State _____ Zip _____

**Patient Information — Use a separate claim form for each family member**

Patient name _____ Date of birth _____ ❒ Male ❒ Female

Relationship: ❒ Member ❒ Spouse ❒ Child ❒ Other _____

Are any of these medications being taken for an on-the-job injury? . . . ❒ Yes . . . ❒ No

**Is the medication covered under any other group health plan?** . . . ❒ Yes . . . ❒ No

If yes, is other coverage: ❒ Primary ❒ Secondary If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of insurer _____ Policy number _____ ID number _____ Phone _____

I certify that I (or my eligible dependent) have received the medication described herein and that the patient named is eligible for drug benefits. I also certify that the medication received is not for treatment of an on-the-job injury or covered under another benefit plan. I understand that Blue Cross and Blue Shield of Texas 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.

**X**_____ _____

Signature of Member or Legal Representation — Date

**PART 2: IMPORTANT!** Please remember to include all **original** pharmacy receipts.

**Please include all receipts with the following information:**

- ■ Pharmacy name
- ■ Prescription number
- ■ Drug name
- ■ Quantity
- ■ NDC number
- ■ Strength
- ■ Date purchased
- ■ Drug charge
- ■ Days supply

**PART 3: PHARMACY INFORMATION.** Pharmacist to complete this section ONLY if original pharmacy receipts not included.

- ■ To ensure that your patient receives accurate and timely reimbursement for medication purchases, please assist in completing the information below.
- ■ If compound prescription, please enter COMPOUND RX in the space designated for the National Drug Code (NDC) number and complete the Compound Prescriptions section on the reverse side.

Pharmacy name _____ Pharmacy NABP number _____

Pharmacy address _____

City _____ State _____ Zip _____ Phone _____

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefit payments as related to the charges listed below will be paid directly to the member.

**X**_____ _____

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

**Rx 1**

| Rx number | Date filled (mm/dd/yyyy) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only) |
|---|---|---|---|---|
| | | | | |

| NDC number | Drug name and strength | Metric quantity | Days supply | Total charge |
|---|---|---|---|---|
| | | | | |

**Rx 2**

| Rx number | Date filled (mm/dd/yyyy) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only) |
|---|---|---|---|---|
| | | | | |

| NDC number | Drug name and strength | Metric quantity | Days supply | Total charge |
|---|---|---|---|---|
| | | | | |

**Rx 3**

| Rx number | Date filled (mm/dd/yyyy) | Prescriber's DEA number | ❒ New ❒ Refill ❒ DAW ❒ Compound | Prior approval code (For office use only) |
|---|---|---|---|---|
| | | | | |

| NDC number | Drug name and strength | Metric quantity | Days supply | Total charge |
|---|---|---|---|---|
| | | | | |

**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 health plan act, which is a crime and subjects such person to criminal and civil penalties.**

## INSTRUCTIONS

**To avoid delays in handling your claim, be sure all information is complete and correct.**

A separate claim form must be completed for:

- Each patient
- Each pharmacy from which you purchase prescription drugs

Obtain additional claim forms from your company or association and mail directly to Blue Cross and Blue Shield of Texas.

## CLAIM SUBMISSION

**When submitting a claim, the following information must be included:**

- Pharmacy name
- Prescription number
- Date of purchase
- Drug name
- Drug strength
- Days supply
- Quantity
- Drug Charge
- NDC number
- Original pharmacy receipts
- Pharmacist's signature
  (only if original pharmacy receipts are not included)

- DO NOT include charges for durable medical equipment that required a prescription to obtain
- DO NOT submit canceled checks, cash register slips or personal itemization; these are not acceptable as substitutes for original receipts
- DO NOT submit statement with "balance" amounts only

## HOW TO COMPLETE THIS FORM

**Member/Patient Information — Complete all member and patient information in Part 1 on reverse side.**

- The member ID number can be found on your member ID card
- The group is the name of your company or association through which you have coverage
- Sign and date in the space provided. Your signature certifies that the information is correct and complete
- Please make a copy of all documents and receipts before you send them to Blue Cross and Blue Shield of Texas; no documents will be returned

## PHARMACY INFORMATION

**Pharmacist to complete Part 3 of the form**

- Indicate pharmacy name, NABP number, address and phone number
- Include Rx number(s), drug name(s), strength(s) and date filled
- Indicate prescriber's DEA number and whether the prescription is new, refill, DAW or compound
- Include NDC number(s) for the drug(s) dispensed
- If a compound prescription, enter the NDC number of the most expensive ingredient of the legend drug used
- Indicate the drug ingredient(s) and quantity
- Indicate the "metric quantity" expressed in number of tablets, grams or mls for liquids, creams, ointments and injectables
- Indicate the "days supply" (number of days the medication will last)
- Indicate the amount paid by the patient
- Sign and date the form
- Pharmacist questions? Call Prime Therapeutics' Contact Center at **800.821.4795**

**COMPOUND PRESCRIPTIONS**
**For pharmacy use only**

| NDC number | Drug ingredient | Quantity | Charge |
|---|---|---|---|
| | | | |
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## MAIL THIS FORM TO

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P.O. Box 64812
St. Paul, MN 55164-0812

www.bcbstx.com

If you have questions, please contact: Customer Service for PPO/POS, Traditional: 800.521.2227; for HMO Blue® Texas Customer Service: 877.299.2377

- **Monday through Friday, 7 a.m. to 11 p.m. CT**
- **Saturday and Sunday, 7 a.m. to 8 p.m. CT**
- **Closed on national holidays**

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