

Prescription Drug Claim Form



BlueCross
BlueShield
of Kansas

PremierBlue

See instructions on reverse.

Patient Information

ID Number
(as it appears on your identification card)

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 Signature _____

Is this medication for an on-the-job-injury or a motor vehicle accident? 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.

Subscriber/Member Information

Name (First, Last) _____

Pharmacy Information

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ ZIP _____

Prescription Claim Information

Original pharmacy receipts are required. Please tape receipts to space provided on the back of 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.)
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.)
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.)
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#
- 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.

3. Call the customer service number on your ID card if you have any questions.
4. Send completed form to:

**Prime Therapeutics
Mail Route BCBSKS
PO Box 14501
Lexington KY, 40512 – 4501**

<p style="text-align: center;">EXAMPLE</p> <p>of how to complete the Prescription Drug Claim Form.</p> <p>1 RX Number <input type="text" value="6"/><input type="text" value="0"/><input type="text" value="1"/><input type="text" value="1"/><input type="text" value="4"/><input type="text" value="8"/><input type="text" value="1"/></p> <p>Date Filled <input type="text" value="0"/><input type="text" value="1"/> / <input type="text" value="1"/><input type="text" value="2"/> / <input type="text" value="0"/><input type="text" value="5"/></p> <p>Quantity <u>30</u> Day Supply <input type="text" value="3"/><input type="text" value="0"/></p> <p>Name of Medication <u>"Drug Name"</u></p> <p>NDC Number <input type="text" value="0"/><input type="text" value="0"/><input type="text" value="1"/><input type="text" value="2"/><input type="text" value="3"/><input type="text" value="4"/><input type="text" value="5"/><input type="text" value="6"/><input type="text" value="7"/><input type="text" value="3"/><input type="text" value="1"/> <small>(Your pharmacist can provide the NDC number identifying the drug.)</small></p> <p>Prescription Cost \$ <input type="text" value=""/><input type="text" value="2"/><input type="text" value="0"/><input type="text" value="5"/> . <input type="text" value="1"/><input type="text" value="4"/></p> <p>Balance Due \$ <input type="text" value=""/><input type="text" value=""/><input type="text" value=""/><input type="text" value=""/> . <input type="text" value=""/><input type="text" value=""/></p>	Rx 1
Rx 2	Rx 3
<p>Pharmacy Receipts Only</p> <p style="margin-top: 100px;">Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.</p> <p>Keep a copy of your receipt(s) for your records.</p>	<p>Pharmacy Receipts Only</p> <p style="margin-top: 100px;">Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.</p> <p>Keep a copy of your receipt(s) for your records.</p>