Prescription Drug Claim Form

BlueCross BlueShield of Kansas

Member information (See other side for instructions)

ID number

Group number

Date of birth / / ❑ Male ❑ Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

❑ Self ❑ Spouse/Domestic partner ❑ Dependent/Child

I certify that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the medicine(s) listed
- I give my permission to share the information on this form with Prime Therapeutics LLC

X

Member or legal representative signature

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

Do you have other insurance for this prescription medicine? ❑ Yes ❑ No

If yes, what is the other insurance company's name?

Cardholder information (primary cardholder)

Name (First, Last)

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

Prescription (Rx) claim information

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

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach original itemized pharmacy receipts. (A cash register receipt is not acceptable.)

1 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number

(Your pharmacist can provide the national drug code (NDC).)

Total prescription charge $.

2 Rx number

Date filled / /

Quantity _____ Days' supply

Name of medicine _____

NDC number

(Your pharmacist can provide the national drug code (NDC).)

Total prescription charge $.

Instructions

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)

Questions?

- You can call the number on the back of your member ID card

3. Keep a copy of this form and pharmacy receipts for your records. Send the original form and pharmacy receipts to:

Prime Therapeutics (Commercial)
Mail route: BCBSKS
PO Box 25136
Lehigh Valley, PA 18002-5136

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 1 6

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

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

(Your pharmacist can provide the national drug code (NDC).)

Total prescription charge $ 2 0 5 . 1 4

Is this prescription claim for a compound medicine?
❑ Yes ❑ No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1	Rx 2
Attach original itemized pharmacy receipts here All required information must be visible (see step 2 above). Keep a copy of this form and your receipt(s) for your records.	**Attach original itemized pharmacy receipts here** All required information must be visible (see step 2 above). Keep a copy of this form and 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 health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.

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