Blue Cross Blue Shield of Kansas City

PRESCRIPTION DRUG CLAIM FORM

YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETE.

PART 1 - TO BE COMPLETED BY EMPLOYEE (SEE INSTRUCTIONS ON BACK)	1. Carrier I.D. No.	2. Group I.D. No.

3. Employee's Name: (Please Print) First	Initial	Last	4. Sex M ☐ F ☐	5. Certificate Number	6. Birthdate Mo. / Day / Yr.

7. Address: Street & Number	City	State	Zip Code	8. Telephone No.

9. Employer's Name

10. Patient's Name: First	Initial	Last	11. Sex M ☐ F ☐	12. Birthdate Mo. / Day / Yr.	13. Relationship to Employee Employee ☐ Spouse ☐ Child ☐ Other ☐

I certify that the above information is correct and that the above person is eligible for benefits. I have received the medication described hereon and authorize release of all information contained in this voucher to Blue Cross and Blue Shield and the underwriter.

I agree that any benefits payable hereunder for medications are not assignable and that any assignment or attempted assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

Signed _____
Employee

Check other applicable coverages, and state name, address and number. If no other coverage, check "None".

Group (or group type) plan ☐ Other ☐
Worker's Compensation ☐ None ☐
Medicare or Medicaid ☐

Other Coverage Name _____
Other Coverage Address _____

PART 2 - PLEASE ASK YOUR PHARMACIST TO COMPLETE THIS PORTION OF THE CLAIM FORM OR SIMPLY ATTACH YOUR ITEMIZED BILLS. WE CANNOT PROCESS THIS CLAIM WITHOUT THIS INFORMATION. IMPORTANT: KEEP COPIES OF ALL BILLS FOR YOUR RECORDS.

1. Rx Number	Date Filled / /	Check One New ☐ Refill ☐	Quantity	Days Supply	Doctor's I.D.	DAW Yes ☐ No ☐	Rx Price	For Blue Cross Blue Shield Use
Medication Name Dosage Form & Strength		Manufacturer Name			NDC Number			

2. Rx Number	Date Filled / /	Check One New ☐ Refill ☐	Quantity	Days Supply	Doctor's I.D.	DAW Yes ☐ No ☐	Rx Price	For Blue Cross Blue Shield Use
Medication Name Dosage Form & Strength		Manufacturer Name			NDC Number			

3. Rx Number	Date Filled / /	Check One New ☐ Refill ☐	Quantity	Days Supply	Doctor's I.D.	DAW Yes ☐ No ☐	Rx Price	For Blue Cross Blue Shield Use
Medication Name Dosage Form & Strength		Manufacturer Name			NDC Number			

4. Rx Number	Date Filled / /	Check One New ☐ Refill ☐	Quantity	Days Supply	Doctor's I.D.	DAW Yes ☐ No ☐	Rx Price	For Blue Cross Blue Shield Use
Medication Name Dosage Form & Strength		Manufacturer Name			NDC Number			

NOTE: BENEFITS ARE PAYABLE DIRECTLY TO THE COVERED INDIVIDUAL ONLY, AND ANY ASSIGNMENT OF THESE BENEFITS IS VOID.

Pharmacy Name _____
Pharmacy Address _____
City/State/Zip _____
Telephone No. _____

Are you a Blue Cross Blue Shield enrolled pharmacy? (circle one) Yes No
Please provide the Pharmacy's NABP No. _____
Pharmacist's Signature _____

RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE BACK.

70-73-4

INSTRUCTIONS FOR FILING A CLAIM

IMPORTANT: Read this form carefully before completing.

This is a sample benefit identification card. Claim forms without all required numbers from your card will not be processed.

CERTIFICATE NUMBER
Refer to part 1, box 5 on front side.

GROUP NUMBER
Refer to part 1, box 2 on front side.

Be sure to copy the information exactly as it appears on your benefit identification card.

IMPORTANT:

1. OBTAIN PRESCRIPTION DRUG CLAIM FORMS FROM YOUR EMPLOYER.
2. KEEP COPIES OF ALL BILLS FOR YOUR RECORDS.
3. USE A SEPARATE CLAIM FORM FOR EACH PATIENT AND EACH PHARMACY.
4. WHEN SHOULD THE CLAIM FORM BE USED? - Employee should use the claim form to receive reimbursement if (a) purchasing prescription drugs at a non-participating pharmacy or (b) purchasing drugs outside the service area.
5. HOW TO FILE AND SUBSTANTIATE A CLAIM? - The employee should complete Part 1 and ask the pharmacist to complete Part 2 of the claim form. Claim form must be completed in full or it will be returned to the employee for completion. AVOID DELAY - COMPLETE ALL REQUIRED AREAS OF INFORMATION.

   NOTE: Any person who knowingly and with intent to deceive or defraud files a claim containing false, incomplete or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.
6. WHERE TO FILE? - Mail completed forms to:

Blue Cross & Blue Shield of KC
Pharmacy Services
P.O. Box 412735
Kansas City, MO 64141-2735