

# Prescription Drug Claim Form

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;"><b>EXAMPLE</b></p> <p style="text-align: center;">of how to complete the Prescription Drug Claim Form.</p> <p><b>1</b> RX Number <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="6"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="8"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/></p> <p>Date Filled <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/> / <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/></p> <p>Quantity <u>    30    </u> Day Supply <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/></p> <p>Name of Medication <u>    "Drug Name"    </u></p> <p>NDC Number <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="6"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="7"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="3"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/></p> <p>(Your pharmacist can provide the NDC number identifying the drug.)</p> <p>Prescription Cost \$ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="2"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="0"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="5"/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="1"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value="4"/></p> <p>Balance Due \$ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/> . <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text" value=""/></p>	<p style="text-align: center; font-weight: bold; font-size: 1.2em;">Rx 1</p> <p style="text-align: center; font-weight: bold; font-size: 1.1em;">Pharmacy Receipts Only</p> <p style="text-align: center; margin-top: 50px;">Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.</p> <p style="text-align: center;">Keep a copy of your receipt(s) for your records.</p>
<p style="text-align: center; font-weight: bold; font-size: 1.2em;">Rx 2</p> <p style="text-align: center; font-weight: bold; font-size: 1.1em;">Pharmacy Receipts Only</p> <p style="text-align: center; margin-top: 50px;">Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.</p> <p style="text-align: center;">Keep a copy of your receipt(s) for your records.</p>	<p style="text-align: center; font-weight: bold; font-size: 1.2em;">Rx 3</p> <p style="text-align: center; font-weight: bold; font-size: 1.1em;">Pharmacy Receipts Only</p> <p style="text-align: center; margin-top: 50px;">Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.</p> <p style="text-align: center;">Keep a copy of your receipt(s) for your records.</p>