Prescription Drug Reimbursement Form

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

medco®

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

Member/Subscriber Information *See your BCBS ID card.*

Group No. BCBSMAN

Contract/ Member ID

Contract/Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex

☐ Female
☐ Male

Relationship to Plan Member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Nonspouse Partner
☐ 8 Other

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

Is this an on-site nursing home pharmacy? ☐Yes ☐No

Claim Receipts

Tape receipts or itemized bills on the back. **See back for details.**

Check the appropriate box if any receipts or bills are for a:

☐ **Compound prescription**
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt or bill.

☐ **Medication purchased outside of the United States**

Please indicate:

Country

Currency used

☐ **Allergy medication**

☐ **Coordination of Benefits**

Please indicate:

Primary insurance carrier

Primary prescription drug program

See back for more information

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Please tape receipts on the back.
Keep a copy for your records.

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11 digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX#		Date Filled		Days Supply	

VALID 11 digit NDC#	Quantity
Total Quantity	
Total Charge	

General Instructions

Read carefully before completing this form

1. You must complete a **separate** claim form for each pharmacy used and for each patient.
2. You must submit claims within 1 year of date of purchase or as required by your plan.
3. **Be sure your receipts are complete.** In order for your request to be processed all receipts must contain the information listed above. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
4. The plan member should read the acknowledgment carefully, then sign and date this form.
5. Return the completed form and receipts to:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

Coordination of Benefits Special Instructions

Primary Insurance carrier

You must first submit the claim to the primary insurance carrier. Once you receive the statement or explanation of benefits (EOB) from the primary carrier, complete this form, tape the prescription receipts above, and attach the statement or EOB from the primary carrier, which clearly indicates the cost of the prescription and what was paid by the primary carrier.

Primary Prescription Drug Program

Retail and Mail Order Pharmacy: If the primary carrier is a prescription drug program, one in which a co-payment or coinsurance is paid to the pharmacy, then no EOB is needed. Just complete this form and attach the prescription receipts or statement of benefits that show the co-payment or coinsurance amount paid to the pharmacy. The receipts will serve as the EOB.

* California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

* Pennsylvania: Any person who knowingly and with intent to defraud any insurance company 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Any questions, call your current Blue Cross Blue Shield of Michigan customer service number.