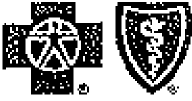

Blue Cross Blue Shield of Kansas City

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

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

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

4. Rx Number	Date Filled	Check One	Quantity	Days Supply	Doctor's I.D.	DAW	Rx Price	For Blue Cross Blue Shield Use
	/ /	New ☐ Refill ☐				Yes ☐ No ☐		
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

79-73-4

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.

Blue Cross
Blue Shield
of Kansas City
Blue-Advantage-65
AN INDEPENDENT LICENSEE OF THE BLUE CROSS BLUE SHIELD ASSOCIATION

YOUR PRIMARY CARE PHYSICIAN MUST AUTHORIZE ALL SERVICES

JOHN Q PUBLIC
000123456789 00
GROUP: 1000000KSMT
BLUE ADVANT 65 PART A & B
BCBSKC RX

25.00 EMER ROOM
0.00 URGENT CARE
10.00 OFFICE VISIT
10.00 SPECIALIST

BC PLAN: 240 BS PLAN 740
PC DENTAL

CUSTOMER SERVICE: 816-395-3062

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