

Prescription Drug Reimbursement Form

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



Subscriber Information *See your ID card.*

Prefix Identification Number
□□□ □□□□□□□□□□

Rx Group Number **BCWAPDP**

Member Name (First, Last)

Street Address

City State Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) □□ □□ □□□□

Gender Relation to Plan Subscriber

- Female 1 Self
- Male 2 Spouse/SSDP
- 3 Dependent

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 claim receipts or itemized bills on the back.
Do not staple!

Check the appropriate box if any of the receipts are for a medication that:

Is a compound prescription.*

Make sure your pharmacist lists ALL the VALID 11-digit NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

ONE CLAIM FORM PER COMPOUND PRESCRIPTION.

Was purchased outside the U.S.A.

If so, please indicate:

Country _____

Currency used _____

Is for treatment of an allergy.

* A compounded medicine is a blend of ingredients that the pharmacist prepares especially for you at your prescriber's request. To be covered under your pharmacy benefit, a compounded medicine must have at least one ingredient that is a prescription drug with an FDA-approved therapeutic indication.

Secondary Prescription Claims

Medicare supplement members need not complete this section.

Submitting claim for secondary prescription reimbursement.

Check one:

- Receipt indicates the total price paid for the prescription.
- Receipt indicates the copayment amount paid under primary plan or other health insurance carrier.
- Explanation of Benefits from primary plan or other health insurance carrier attached.

For secondary claim submission only

Return the completed form and receipt(s) to:

Premera Blue Cross Blue Shield of Alaska
PO Box 240609
Anchorage, AK 99524-0609

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for 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 Patient (or legal guardian if patient cannot legally consent to services)

Date / /

