Prescription Drug Reimbursement Form

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

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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
☐ Female
☐ Male

Relation to Plan Subscriber
☐ 1 Self
☐ 2 Spouse/Domestic Partner
☐ 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 **Date** / /

Signature of Patient (or legal guardian if patient cannot legally consent to services)

Claim Receipts

Please tape your receipts here. **Do not staple!** Tape additional non-compound receipts 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	

Direct Reimbursement Claim Instructions

Read carefully before completing this form.

1. Always present your ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid a pharmacy full price for a prescription drug order because:
   - the pharmacy does not accept your ID card.
   - you have not received your ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within one year of date of purchase or as required by your Plan.
5. **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 it is not itemized on your claim or bill.
6. You should read the Acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipt(s) to:

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

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.

Questions? Call the Premera Blue Cross Blue Shield of Alaska Customer Service number listed on the back of your ID card or visit *www.premera.com*.

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