Prescription Drug Reimbursement Claim Form

Be sure to complete the **detail claim information** on the back of this form.
Claims **may** be returned if incomplete.

Blue Cross Blue Shield of Michigan

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

Cardholder information (refer to your BCBSM ID card. Enrollee ID should be NUMERIC ONLY)

NOTE: USE THE ID# YOU WANT THE SERVICES PROCESSED UNDER.

Group No. ☐

Enrollee ID ☐

Enrollee name: First (listed on your BCBSM ID card) Last

Street address

City State ZIP

Daytime Telephone (include area code) ☐☐☐-☐☐☐-☐☐☐☐

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 Non-spouse 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**

Please Check your RxGrp

(Refer to your BCBSM ID card)

- ☐ **BCBSMRX1**
- ☐ **BCBSMAN**

Check the appropriate box if your receipt or bill is for:

- ☐ **Compound prescription**
  Make sure your pharmacist lists ALL the VALID NDC numbers, cost and quantities for **each ingredient** on the back of this form and **attach receipts**. Claim may be returned if incomplete.
  ONE CLAIM FORM PER COMPOUND SUBMISSION
- ☐ **Foreign - medication purchased outside of the United States**
  Note: For foreign claims, please complete additional foreign claim reimbursement form.
  Please indicate:
  Country ____________________
  Currency used ____________________
- ☐ **Allergy medication**

COORDINATION OF BENEFITS

If another health plan has paid a portion, please see the additional coordination of benefits instructions on the back.

Is this a coordination of benefits claim?

☐ Yes ☐ No

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.†

Acknowledgment

I certify that the medication(s) described 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 certify that the medication(s) described were not for an on-the-job injury. *By completing this form, 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 – **(REQUIRED)** Date

In the future, please ask your pharmacy to bill your services electronically. We have over 50,000 pharmacies in our network.

Express Scripts is an independent company that provides pharmacy services for Blue Cross Blue Shield of Michigan.

Claim receipts: Receipts are required (keep a copy for your records). Please complete the detail claim information below and contact your pharmacy for missing information. Claims may be returned if incomplete.

Note 1: If these are foreign receipts you must also complete the foreign claim reimbursement form.
Note 2: If your coverage only provides a discount on prescriptions, you cannot submit this claim for reimbursement.
Note 3: You cannot get reimbursed for claims if the date of service is older than one year.

LINE NO.	DATE OF SERVICE MO / DAY / YEAR	PRESCRIPTION #	NAME OF DRUG	NATIONAL DRUG CODE (NDC is 11 digits)	QTY	DAY SUPPLY	MEMBER PAID
1							
2							
3							
4							
5							
6							

COMPOUND PRESCRIPTIONS ONLY

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

Rx #

Date filled __/__/____ Day supply Quantity

Valid 11-digit ingredient NDC Number	Metric quantity	Ingredient cost
	Total charge	

Instructions Read carefully before completing this form.

1. Always present your prescription drug ID card at the participating retail pharmacy and request they submit your prescription electronically.
2. Use this form when you have paid full price for a prescription drug at a retail pharmacy or need to submit claims for Coordination of Benefits.
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.
5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed at the top of this page. Your pharmacist can provide the necessary information if your claim or bill is not itemized.
6. The plan member should read the acknowledgment carefully, and then sign and date this form.
7. **Return the completed form and receipt(s)** to:
   Express Scripts
   ATTN: Commercial Claims
   P.O. Box 14711
   Lexington, KY 40512-4711
8. You may also **fax your claim form to: 608.741.5475**.

Please use one claim form per fax.
Do not combine claims for different members in the same fax submission.

Any questions, call your Blue Cross Blue Shield of Michigan customer service number, which is located on the back of your ID card. Visit us at **bcbsm.com.**

ADDITIONAL COORDINATION OF BENEFITS INSTRUCTIONS

Another health plan paid

You must first submit the claim to the primary insurance carrier. Once you receive the statement from the primary plan, complete this form and indicate the secondary group number and Enrollee ID in the cardholder information section. Attach the original receipts and the statement from the primary plan to this form. The primary plan statement should clearly indicate the cost of the prescription and what was paid by the primary plan.

Prescription drug programs or HMO Plans

Coordination of benefits
If the primary plan processed the claim at a retail pharmacy, then no explanation of benefits is needed. Just complete this form and attach the prescription receipt(s) that shows the copayment or coinsurance amount paid at the pharmacy. The receipt(s) will serve as the explanation of benefits.

Mail Order Pharmacy
If the primary plan processed the claim, complete this form and attach either the prescription receipt(s) that shows the copayment or coinsurance amount paid or the statement of benefits you received.

† **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.

© 2014 Express Scripts Holding Company. All Rights Reserved. C 8 1 0 5 (12-1608 rev 8/15)