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Federal Employee Program
RETAIL PRESCRIPTION DRUG OVERSEAS CLAIM FORM

INSTRUCTIONS

- This form is to provide direct reimbursement for prescriptions that were purchased outside the United States.
- Pharmacy receipts or the pharmacist's signature required.
- Please use a separate claim form for each patient.
- Do not staple receipts or attachments to this form.

ENROLLEE'S OR POLICY HOLDER'S INFORMATION REQUIRED:

Insured's Name: Tracy Rice
Street Address: PSC 80 Box 11399
City: APO State: AA Zip: 916367
Province: _____ County/Code: _____

ENROLLMENT CODE

105

IDENTIFICATION NUMBER

R59095333

I certify that the information is correct and complete and that I am claiming benefits only for the charges for the patient named above. Authorization is hereby given to any provider of service who participated in any way in the patient's care, to release any medical information which they deem necessary to adjudicate this claim. I also authorize release of all information contained on this claim to AdvancePCS and the plan administrator. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment of these benefits shall be void.

ENROLLEE'S OR PATIENT'S SIGNATURE REQUIRED:

PATIENT INFORMATION REQUIRED:

Patient Name: LAST RICE FIRST TRACY
Date of Birth: 05 15 1967 Male: ☐ Female: ☒
Patient's Relationship to Insured: Self ☒ Spouse ☐ Dependent ☐

FOREIGN COUNTRY INFORMATION:

Currency Type: Yen PHARMACIST'S SIGNATURE: (Required if receipts or bills are not attached)

Country Where Drugs Purchased: Japanese

PRESCRIPTION CLAIM INFORMATION:

1 Rx #: _____ New or Refill (circle one) Date Filled: 06 16 2019 Quantity (ml, #tablets, gm.) 21

Days Supply: 7 DAYS Name of Medication: Augmentin
NDC#: _____ U.S. Drug Equivalent Name: Augmentin
Form of Medication (capsules, cream, etc.): capsules Dosage (250 mg., etc.): 375mg
Prescription Cost: amount paid in ¥2,310.00 Foreign currency: Japanese Yen

2 Rx #: _____ New or Refill (circle one) Date Filled: 06 11 2019 Quantity (ml, #tablets, gm.) 42

Days Supply: 7 DAYS Name of Medication: Antibiotic
NDC#: _____ U.S. Drug Equivalent Name: _____
Form of Medication (capsules, cream, etc.): capsules Dosage (250 mg., etc.): 250mg
Prescription Cost: amount paid in ¥2,440.00 Foreign currency: Japanese Yen

3 Rx #: _____ New or Refill (circle one) Date Filled: _____ Quantity (ml, #tablets, gm.) _____

Days Supply: _____ Name of Medication: _____
NDC#: _____ U.S. Drug Equivalent Name: _____
Form of Medication (capsules, cream, etc.): _____ Dosage (250 mg., etc.): _____
Prescription Cost: amount paid in _____ Foreign currency: _____