Prescription Drug Claim Form

See instructions on reverse.



Patient Information	Prescription Claim Information
ID Number	Original pharmacy receipts are required. Please attach receipts to space provided on the back of form. If receipts are not included, please have pharmacist complete and sign the bottom of this form.
Group Number	Was this prescription medication purchased outside the U.S.A.? □ Yes □ No
Date of Birth / Male Female	All fields below must be completed. (Example on back of form.) Call your pharmacist if you need assistance.
Patient Name (First, Last)	1 Rx Number
Street Address	Date Filled / / / /
	Quantity Day Supply
City State ZIP	Name of Medication
Patient's Relationship to Subscriber/Member:	NDC Number
☐ Self ☐ Spouse ☐ Dependent	NDC Number (Your pharmacist can provide the NDC number identifying the drug.)
I certify that the information is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein and authorize release of all information contained on this claim form to	NPI Number
Prime Therapeutics. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further	Prescription Cost \$
represent that there has been no assignment of benefits hereunder. I understand that Blue Cross and Blue Shield of Oklahoma use or disclosure	Balance Due \$.
of individually identifiable health information, whether furnished by me or obtained from other sources such as medical or pharmacy providers, shall be in accordance with the federal privacy regulations under HIPAA (Health	2 Rx Number
Insurance Portability and Accountability Act of 1996). Any person who knowingly presents a false or fraudulent claim for the payment of a loss is quilty of a crime and may be subject to fines and confinement in state prison.	Date Filled / / /
guilty of a crime and may be subject to fines and confinement in state prison.	Quantity Day Supply
Patient/Subscriber/Member or Legal Representative Signature	Name of Medication
Is this medication for an on-the-job-injury? □ Yes □ No	NDC Number
Do you have other insurance	(Your pharmacist can provide the NDC number identifying the drug.)
for prescription medications?	NPI Number
If yes, please provide Name of other Insurance:	Prescription Cost \$.
Policy Number:	Balance Due \$.
Please include any pharmacy receipts related to this claim with this form.	2
Subscriber/Member Information	Rx Number / / / / Date Filled
Name (First, Last)	Quantity Day Supply
Pharmacy Information	Name of Medication
,	NDC Number
Pharmacy Name	(Your pharmacist can provide the NDC number identifying the drug.)
	NPI Number
Pharmacy Address	Prescription Cost \$
City State ZIP	Balance Due \$.
x	
Signature of Pharmacist or Representative (Required only if original pharmacy	y receipts are not included) Date

Pharmacy/Prescription Information

- 1. Use a **separate claim form** for each patient. All information provided on or attached to this claim form must be for the same patient.
- 2. Tape or glue pharmacy receipts in the spaces provided. When you tape or glue your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the taped or glued receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:
 - Patient Name

- Quantity
- Pharmacy Name/Address
- Fill Date

Total Charge

- Rx Number
- Drug Name and NDC Number
- NPI Number

5. Send completed form to:

information.

have any questions.

any questions.

Prime Therapeutics P.O. Box 14624

Lexington, KY 40512-4624

· Days Supply

	EXAMPLE of how to complete the Prescription Drug Claim Form.											
1	RX Number 0 0	0	0	0	6	0	1	1	4	8	ı	
	Date Filled O I	/	I	2	/	C	5					
	Quantity30					_ Day Supply 3 0					0	
	Name of Medication "Drug Name"											
	NDC Number (Your pharmacist ca	O an pr	<i>O</i> ovide	I the	2 NDC	3 C nur	4 nber	5 iden	<i>ර</i> tifyir	チ ng the	3 e dru	I Ig.)
	NPI Number	9	2	l	5	2	4	l	l	6	3	
	Prescription Cost	\$		2	0	5	.	l	4			
	Balance Due	\$		2	0	5	.	ı	4			

Is this prescription claim for a compound medication? ☐ Yes
☐ No

Note: If yes, make sure your pharmacist completes the information below.

Compound Information:

If a compound prescription, please enter all information per drug used.

Compound Prescriptions

If any of your receipts do not have **required** information,

Write that information on your receipt(s). If not completed,

the claim will be sent back for the required information.

3. Call the customer service number on your ID card if you

4. Have your pharmacist call 800.821.4795 if he/she has

ask your pharmacist to provide you with the missing

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 2 Rx 1

Pharmacy Receipts Only

Pharmacy Receipts Only

Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

Tape or glue one pharmacy receipt in this space. If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

On behalf of Blue Cross and Blue Shield of Oklahoma, PrimeMail mail order pharmacy services are provided by Prime Therapeutics, a Blues-focused pharmacy benefit management company. Prime Therapeutics is owned by 10 Blue Cross and Blue Shield Plans, including Health Care Service Corporation. Blue Cross and Blue Shield of Oklahoma is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.