Prescription Drug Claim Form

See instructions on reverse.

BlueCross BlueShield of Montana
Live Smart. Live Healthy.℠

Patient Information

ID Number

Group Number

Date of Birth ☐☐ / ☐☐ / ☐☐ ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

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 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 represent that there has been no assignment of benefits hereunder.

Patient/Subscriber/Member Signature

Is this medication for an on-the-job-injury or a motor vehicle accident? . . . . . ❑ Yes ❑ No

Do you have other insurance for prescription medications? . . . . . ❑ Yes ❑ No

If yes, please provide
Name of Insurance:

Policy Number:

Please include any pharmacy receipts related to this claim with this form.

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

Original pharmacy receipts are required. Please tape receipts to space provided on the back of form.

Was this prescription medication purchased outside the U.S.A.? . . . . . ❑ Yes ❑ No

All fields below must be completed.
(Example on back of form.)
Call your pharmacist if you need assistance.

1 Rx Number

Date Filled ☐☐ / ☐☐ / ☐☐

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescription Cost $. ☐☐

Balance Due $. ☐☐

2 Rx Number

Date Filled ☐☐ / ☐☐ / ☐☐

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescription Cost $. ☐☐

Balance Due $. ☐☐

3 Rx Number

Date Filled ☐☐ / ☐☐ / ☐☐

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescription Cost $. ☐☐

Balance Due $. ☐☐

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
   - Pharmacy Name/Address
   - Total Charge
   - Drug Name and NDC#
   - Quantity
   - Fill Date
   - Rx#
   - Days Supply

   If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing 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 have any questions.
4. Have your pharmacist call 800.821.4795 if he/she has any questions.
5. Send completed form to:

   Prime Therapeutics
   P.O. Box 14430
   Lexington, KY 40512-4430

To find a network pharmacy in your area, please call our pharmacy locator toll free at **866.325.5230**.

EXAMPLE
of how to complete the Prescription Drug Claim Form.

1 RX Number 6011481

Date Filled 01 / 12 / 05

Quantity 30 Day Supply 30

Name of Medication "Drug Name"

NDC Number 00123456731

(Your pharmacist can provide the NDC number identifying the drug.)

Prescription Cost $ 205 . 14

Balance Due $.

Rx 1

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.

Rx 2

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.

Rx 3

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.