BlueCross® BlueShield® Blue Crescent℠

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 and Enrollee/Patient signature are required.**
- Please use a separate claim form **for each patient.**
- **Do not staple receipts or attachments to this form.**
- **See instructions on the back of the claim form.**

ENROLLEE'S OR POLICY HOLDER'S INFORMATION REQUIRED:

Insured's Name: _____

Street Address: _____

City: _____ State: ☐☐ Zip: ☐☐☐☐☐

Country: _____

IDENTIFICATION NUMBER

R ☐☐☐☐☐☐☐☐☐

Mail Completed Form To:

Service Benefit Plan
Retail Pharmacy Program
P.O. Box 52057
Phoenix, AZ 85072-2057

I certify that the information is correct and complete and that I am claiming benefits only for the charges for the patient named below. 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 CVS Caremark 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.

PATIENT INFORMATION REQUIRED:

Patient Name: LAST ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ FIRST ☐☐☐☐☐☐☐☐☐☐

Patient's Relationship to insured: Self ☐ Spouse ☐ Dependent ☐

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ Male: ☐ Female: ☐

FOREIGN COUNTRY INFORMATION:

Country Where Drugs Purchased: _____

PRESCRIPTION CLAIM INFORMATION: (one medication per line)

Date Purchased MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ Quantity (how many) ☐☐☐☐ Days Supply: _____

Name of Medication _____

U.S. Drug Equivalent Name _____

Form of Medication (capsules, cream, etc.) _____ Strength (250 mg., etc.): _____

Prescription Cost: _____ Country Currency Type _____

Date Purchased MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ Quantity (how many) ☐☐☐☐ Days Supply: _____

Name Of Medication _____

U.S. Drug Equivalent Name _____

Form of Medication (capsules, cream, etc.) _____ Strength (250 mg., etc.): _____

Prescription Cost: _____ Country Currency Type _____

Date Purchased MONTH ☐☐ DAY ☐☐ YEAR ☐☐☐☐ Quantity (how many) ☐☐☐☐ Days Supply: _____

Name Of Medication _____

U.S. Drug Equivalent Name _____

Form of Medication (capsules, cream, etc.) _____ Strength (250 mg., etc.): _____

Prescription Cost: _____ Country Currency Type _____

Enrollee/Patient Signature: _____ **Date:** _____

General Information
This Retail Prescription Drug Overseas Claim Form is to be used only to submit a claim for benefites for prescription drugs purchased outside of the United States and Puerto Rico. Please complete a separate claim form for each patient and remember to file all claims by December 31 of the calendar year after the one in which the purchase was made.

The Retail Prescription Drug Overseas Claim Form must be completed in full and accompanied by the prescription drug receipts/bills. **ENROLLEE/PATIENT SIGNATURE REQUIRED.**

Please be sure to keep photocopies of the claim form and all bills and supporting documentation for your personal records.

Any person who knowingly and with intent to defraud any insurance company or other person files a claim for reimbursement containing any materially false information or conceals for the purpose of misleading commits a fraudulent insurance act, which is a crime and subject to criminal and civil penalties

Prescription Claim Information – Please list the prescriptions included on this claim. Although we require prescription drug receipts, your listing will enable us to process the claim more quickly and accurately.

- Date Purchased - The date you paid for the prescription.
- Quantity - The number of tablets, capsules, or the liquid measure of the prescription.
- Days Supply - The number of days for which the prescription was written.
- Name of Medication - The name of the medication as indicated on the prescription drug receipt.
- U.S. Drug Equivalent Name - The name of the prescription drug in English.
- Form of Medication - Such as a cream, tablets, capsules, liquid, etc.
- Strength - This is the strength of medication per dose, such as 50 mg for tablets or .05 ml for liquids.
- Prescription Cost - Please indicate the cost you paid in foreign currency.

THIS SIGNED AND COMPLETED CLAIM FORM, TOGETHER WITH YOUR PRESCRIPTION DRUG RECEIPTS/ BILLS SHOULD BE SUBMITTED TO THE ADDRESS ON THE FRONT OF THE FORM, OR YOUR CAN FAX TO: 001-480-614-7674.

DIRECT DEPOSIT TO YOUR BANK ACCOUNT IS CURRENTLY NOT AVAILABLE FOR OVERSEAS PHARMACY CLAIMS PAYMENT. PAYMENT WILL BE MADE BY CHECK IN U.S. CURRENCY.

PLEASE USE THE FEDERAL EMPLOYEE PROGRAM OVERSEAS MEDICAL CLAIM FORM FOR ALL OTHER MEDICAL EXPENSES INCURRED OUTSIDE THE US AND PUERTO RICO.

ADDITIONAL CLAIM FORMS OR INFORMATION ARE AVAILABLE ON OUR WEB SITE, www.fepblue.org. OR BY CALLING 1- 888-999-9862.