BlueCross BlueShield
Federal Employee Program

RETAIL PRESCRIPTION DRUG CLAIM FORM
Service Benefit Plan for Federal Employees and Retirees

AREA FOR DOCUMENTS

PLEASE TYPE OR PRINT **IN ALL CAPITAL LETTERS**. SEE REVERSE FOR INSTRUCTIONS.

IDENTIFICATION NUMBER

R

Mail Completed Form To:

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

For Information, call 1-800-624-5060

ENROLLEE INFORMATION

ENROLLEE'S Last Name | First Name | Initial

Street Address | Apartment Number, Suite OR P.O. Box Number

City | State | Zip Code

☐ *MARK IF NEW ADDRESS*

PATIENT INFORMATION

PATIENT'S NAME Last | First | Initial

PATIENT'S DATE OF BIRTH MONTH DAY YEAR

PATIENT'S SEX ☐ Male ☐ Female

PATIENT'S RELATIONSHIP TO ENROLLEE ☐ Self ☐ Spouse ☐ Child

▶ Is the patient covered by additional health Insurance coverage through an employer, a group, such as a professional organization, or any other group health insurance including Blue Cross and/or Blue Shield coverage? ☐ Yes ☐ No If yes, effective date of coverage _____

Please attach a copy of the NOTICE OF PAYMENT or EXPLANATION OF BENEFITS from the other insurer, if available.

▶ Did the patient use a prescription drug card from the other insurer when purchasing these prescriptions? ☐ Yes ☐ No

PHARMACY INFORMATION

PHARMACY NAME _____

STREET _____

CITY, STATE, ZIP _____

PHARMACY ID # or NABP # (If Available)

PHONE _____

PRESCRIPTION INFORMATION

Complete all prescription information boxes below. If you do not have all the information, please call your pharmacist. Please see instructions on the reverse side of this claim form.

	RX NUMBER	DATE RX FILLED (MONTH DAY YEAR)	$ AMOUNT CHARGED	PRESCRIBING PHYSICIAN'S DEA NUMBER OR NAME	IS THIS A COMPOUND? ☐ YES
1.					
2.					
3.					
4.					

ENROLLEE CERTIFICATION

I certify that the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, which participated in any way in my care, to release to the Blue Cross and Blue Shield Plan any medical information which they deem necessary to adjudicate this claim.

ENROLLEE'S SIGNATURE | DATE

Instructions

1. Please complete a separate claim form for each patient and each pharmacy. Each claim form must be signed.

2. **When you have completed this form, please include your itemized receipts. A pharmacist's signature is required on all handwritten receipts. We recommend you keep copies for your records.**

3. **You must answer the other prescription drug insurance questions in the Patient Information Section on the front of this form or your claim will be returned.**

4. Itemized receipts for covered prescriptions are required and must include the following:
   - NABP number or the current name and complete address of pharmacy
   - Full name of the patient
   - Date filled
   - Name of drug, strength (e.g., 500 mg) and dosage form (e.g., capsules, liquid or cream)
   - Prescription number
   - Quantity
   - Charge for each prescription

5. **"DAYS SUPPLY" must be included on the claim form.**
   Calculate your days supply like this: QUANTITY ÷ DOSAGE = DAYS SUPPLY
   QUANTITY - Total number of units (pills, tablets, capsules)

   DIVIDED BY

   DOSAGE - Total number of doses per day (one a day, 3 times a day)
   Example: You have 90 tablets and you take 3 tablets per day i.e. 90 ÷ 3 = 30 DAYS SUPPLY

6. Only claims for prescriptions purchased from a retail pharmacy are to be sent to the address on the front. Claims for all other services should be sent to your local Blue Cross/Blue Shield Plan using a Federal Employee Program Health Benefits Claim Form. Example of claims sent to your local Blue Cross and/or Blue Shield Plan includes:
   - Drugs dispensed by a physician or hospital including allergy sera
   - Home health care medications
   - Durable medical equipment

7. Claims must be submitted promptly, but in any case no later than December 31 of the calendar year following the year in which the drug was purchased.

Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine or not more than $10,000 or imprisonment of not more than 5 years, or both, (18 U.S.C. 1001).

Prescription drug benefits under the Service Benefit Plan are subject to the terms, limitations and exclusions stated in the Service Benefit Plan brochure including "If the provider waives your share" in the Cost Share Section. The Billed charge must be no more than the pharmacy's normal retail charge.