# Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

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Blue Cross Blue Shield of Michigan
Independent Licensee of the Blue Cross and Blue Shield Association.

## Member/Subscriber Information *See your member ID card.*

Group No. B C B S M A N

Member ID/Contract Number

Member/Contract Holder Name (First, Last)

Street Address

City State Zip

## Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

*Sex*
- ☐ Female
- ☐ Male

*Relation to Plan Member*
- ☐ 1 Self
- ☐ 2 Spouse
- ☐ 3 Eligible Child
- ☐ 4 Dependent Student
- ☐ 5 Disabled Dependent
- ☐ 6 Dependent Parent
- ☐ 7 Other
- ☐ 8 Non-spouse Partner

## Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code)

**Is this an on-site nursing home pharmacy? ☐Yes ☐No**

I hereby certify that the charge(s) shown for the medications prescribed is/are correct and agree to provide Medco Health or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Pharmacist or Representative **(Required)**

**NABP Number Required**

## Claim Receipts

Tape claim receipts or itemized bills on the back.
**Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

☐ **Is a compound prescription.**
Make sure your pharmacist lists ALL the NDC numbers and quantities for each ingredient on the back of this form and attach receipts. Claim will be returned if incomplete.

**ONE CLAIM FORM PER COMPOUND SUBMISSION.**

☐ **Was purchased outside the U.S.A.**
If so, please indicate:

Country

Currency used

☐ **Is for treatment of an allergy.**

☐ **Is for Betaseron.**

**Please tape receipts on the back**

## Acknowledgment

I certify that the medication(s) described above was/were received for use by the patient listed above, and that I (and the patient, if not myself) am eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

## Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

**Receipts must contain the following information:**

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for prescription 2 here.

**Receipts must contain the following information:**

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

## PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List each NDC number for ALL ingredients used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

**RX#:** **DOS:** **DS:**

| NDC# | QTY |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| TOTAL CHARGE | |

## Direct Reimbursement Claim Instructions

**Read carefully before completing this form.**

1. Always present your Blue Cross Blue Shield of Michigan ID card at the participating retail pharmacy.
2. Only use this claim form when you have paid full price for a prescription drug order at a pharmacy because:
   - The pharmacy does not accept your BCBSM ID card, or
   - You have not received your BCBSM ID card.
3. You must complete a **separate** claim form for **each pharmacy** used and for **each patient.**
4. You must submit claims within one year of date of purchase or as required by your plan.
5. **Be sure your receipts are complete.** In order for your request to be processed, all receipts must contain the information listed above. Your pharmacist can provide the necessary information if it is not itemized on your claim or bill.
6. The plan member should read the acknowledgment carefully, then sign and date this form.
7. Return the completed form and receipt(s) to:

   **Medco Health**
   **P.O. Box 2096**
   **Lee's Summit, MO 64063-7096**

**Any questions, call your current Blue Cross Blue Shield customer service number.**

Visit us on the Web at **www.medcohealth.com**.