



Prescription Drug Claim Form

PART ONE: To Be Filled Out By You

Date Submitted: MM / DD / YY

MEMBER NUMBER, MEMBER NAME, STREET ADDRESS, CITY, STATE, ZIP, DAYTIME TELEPHONE

PATIENT'S NAME (FIRST AND LAST), PATIENT'S DATE OF BIRTH (MM/DD/YY), PATIENT IS: MALE, FEMALE, MEMBER, SPOUSE, CHILD, STUDENT, Check if coverage was provided by another insurance company.

The undersigned certifies that the medication described hereon was received by the undersigned for the party named below who is eligible for drug benefits, and that such medication is not for an on the job injury or covered under another benefit plan.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Pharmacy Information (Affix Computer Receipt For Each Prescription)

NUMBER OF PRESCRIPTIONS (Rx) ATTACHED: _____

PHARMACY NAME, ADDRESS, PHARMACY ACCOUNT NUMBER, CITY, STATE, ZIP, PHARMACY TELEPHONE

Rx1 TAPE RECEIPT: NO STAPLES. The receipts must contain the following information: Date Prescription Filled, Name and Address of Pharmacy, NDC Number, Name of Drug and Strength, Quantity, Days Supply, Prescription (Rx) Number, Amount Paid

Rx2 TAPE RECEIPT: NO STAPLES

Rx3 TAPE RECEIPT: NO STAPLES

Rx4 TAPE RECEIPT: NO STAPLES

DIABETIC AND/OR OSTOMY SUPPLIES. Ask your pharmacist to submit these just like prescription items. You'll be able to enjoy discounts where applicable and all necessary information for processing will be on your receipt(s).

COMPOUNDS. If any of the above Rx's are compounds, ask your pharmacist to list all the ingredients and quantities.

HELPFUL HINTS

Use this form for the following programs:

- Blue RxSM Member claims
- DrugCard Member claims where the member forgets to show his ID Card or uses a non-participating pharmacy.

DO's

Go to a participating pharmacy.

Show your ID Card.

Use a separate form for each family member.

Completely fill out Part One of the claim form.

Attach drug receipt(s). The receipts must contain the following information:

- Date prescription filled
- Name and Address of Pharmacy
- NDC Number
- Name of Drug and Strength
- Quantity
- Days Supply
- Prescription (Rx) Number
- Amount Paid

DON'Ts

Don't forget to show your ID Card.

Don't attach more than one family member's receipts to one claim form. Use a separate form for each family member.

Don't forget to attach drug receipt(s).

Don't send your physician bills to the Phoenix address.

If you have any questions about completing this form, call 1-888-963-7290.

**Mail your claim to:
BlueCross BlueShield of South Carolina
c/o Caremark
P.O. Box 52059
Phoenix, AZ 85072-2059**
