Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Foreign Prescription Drug Reimbursement Claim Form

Must be submitted with the "Prescription Drug Reimbursement Claim Form"

You may qualify for a vacation override on future foreign claims. For more information, call the Customer Service number located on the back of your Blue Cross Blue Shield of Michigan member ID card.

Instructions:

- Complete a new claim form for each patient.
- Attach your itemized paid drug receipt.
- Complete the "Prescription Drug Reimbursement Claim Form" and submit it with this claim form.
- Complete all requested information. Your claim will be returned for missing or incorrect information.

Enrollee ID (last nine numbers only) *Example:* X4Z123456789	Patient name	Patient date of birth

☐ Country of Purchase: _____ ☐ Currency used: _____

Prescription Information

	Date of service (MM/DD/YYYY)	Name of prescription	Form (ex: tablet, capsule, liquid)	Dose (ex: 500mg, 75mcg, 0.1%)	Quantity	Day supply (ex: 30-day supply)	Amount paid (per drug)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

If your prescription doesn't have an FDA approved American Equivalent, the claim won't be paid.

Acknowledgment

I certify that the medication described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits.

X _____

Enrollee or patient signature - **(REQUIRED)** Date