Prescription Blue℠

Blue Cross Blue Shield of Michigan

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

PRESCRIPTION DRUG CLAIM FORM

BCBSM Part D Claims Department
C/O MedImpact
PO Box 509108
San Diego, CA 92150-9108

Submit this completed form to the address above with the original receipt(s) and prescription label(s). Please make a copy of all submitted documents for your records. Claims must be received within 150 days from the date of service.

Cardholder Information

Cardholder RX ID Number	Cardholder Name (First, Middle, Last)	Cardholder DOB (MM/DD/YYYY)

Cardholder Phone Number: ( )

Other Health Insurance Information

Do you have other prescription drug coverage? No ☐ Yes ☐	Policy #
Name of other insurance company	Cardholder name (First and Last Name)

Street Address for other insurance company	City	State	Zip Code

Claim Information

Medication Name	Prescribing Physician's Name/ NPI # / DEA # / NABP #
Coordination of Benefits Other Carrier Liability Claim Yes ☐ No ☐	Compound Yes ☐ No ☐

Vaccine Administration Fee (if applicable) $	Location where vaccine was administered (if applicable) Pharmacy ☐ Physicians Office ☐	Date Vaccine Administered

Emergency Fill Yes ☐ No ☐ If yes, please explain:

_____

_____

Pharmacy/Provider of Service Information

Pharmacy/Provider Name	Pharmacy/Provider Telephone Number ( ) -		NPI # / DEA # / NABP #
Pharmacist /Provider Signature (If you do not have the label and receipt, your pharmacy must complete and sign form.)			Date
Pharmacy/Provider Street Address	City	State	Zip

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Cardholder Signature _____

Warning: It is a crime to provide false information or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.