Prescription drug reimbursement claim form

Please fill out the following form completely. An incomplete form may delay your reimbursement.

Blue Cross Blue Shield Blue Care Network of Michigan

Form instructions

- Complete this claim form if you paid full price for a prescription and the pharmacy did not submit a claim to Blue Cross Blue Shield of Michigan and Blue Care Network, or if you are submitting a claim for coordination of benefits.
- Complete a separate claim form for each patient and each prescribing physician or pharmacy used.
- Include a pharmacy receipt for each prescription submitted for reimbursement.
- Read the acknowledgment carefully, and sign and date the claim form. A signature is required to process your claim.
- Return the completed claim form and pharmacy receipts to:

  OptumRx Manual Claims
  P.O. Box 650334
  Dallas, TX 75265-0334

For more information, call the Customer Service number located on the back of your Blue Cross or BCN member ID card.

Form requirements

- Claims must be submitted within one year of the date of service. Claims more than one year old will not be reimbursed.
- Pharmacy receipts are required for each prescription. Cash register receipts are not accepted. If you don't have a pharmacy receipt, ask your pharmacy to provide one to you.
- BCBSM cannot process requests for reimbursement for members with delinquent or unpaid premiums.
- The following information is required to process your claim. Refer to your pharmacy receipt or contact your pharmacy for missing information.
  - Patient first and last name and date of birth
  - Prescribing physician first and last name and national provider identifier number
  - Pharmacy name, address, telephone number and national provider identifier number
  - Date of service
  - Prescription number
  - Name and strength of prescription
  - National drug code
  - Quantity
  - Days' supply
  - Amount paid

Foreign prescription

- You may qualify for a vacation supply of your prescription prior to traveling outside of the United States. For more information, call the Customer Service number located on the back of your Blue Cross or BCN member ID card.
- Medication purchased outside of the United States must have an FDA-approved American equivalent to be considered for reimbursement. Prescription reimbursement for foreign claims is not available for BCN members.
- Medication purchased and shipped to you from a pharmacy outside of the United States will not be reimbursed.
- The following information is required to process a foreign claim:
  - Country
  - Currency used

Prescription information

This prescription is for:

☐ **Allergy serum prescription**

☐ **Compound drug prescription** – Ask your pharmacist to complete the "Compound prescription" section of this claim form.

☐ **Foreign prescription**

Please indicate:

Country: ______________________________

Currency used: ______________________________

Coordination of benefits instructions

- The claim must first be submitted to your primary prescription drug plan for consideration of payment. Once the primary plan has processed the claim, complete this claim form.
- Check the box for "Another health plan paid a portion" in the "Coordination of benefits section.
- Attach the explanation of benefits statement from your primary plan. The EOB statement should clearly indicate the cost of the prescription and what was paid by the primary plan. If the primary plan didn't provide an EOB statement, attach the pharmacy receipt. An EOB or pharmacy receipt is required to process your claim.

Coordination of benefits

If Blue Cross or BCN is your secondary prescription drug plan, complete the following steps for consideration of payment. Check the appropriate box:

☐ Another health plan paid a portion

☐ Discount card or coupon was used

OptumRx® is an independent company providing home delivery pharmacy and other pharmacy benefit administration services for Blue Cross Blue Shield of Michigan and Blue Care Network."

Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

Member information – *See your member ID card.*

RxGRP: ☐ BCBSMRX1 ☐ BCBSMAN ☐ BCNRX				
Group number	Subscriber ID *(include all letters and numbers)* -			
Subscriber name *(first and last)*		Daytime telephone number *(include area code)* - -		
Mailing street address	Apt. No.	City	State	ZIP code

Patient information

Prescription is for: ☐ Self ☐ Spouse ☐ Dependent		
Patient first name	Patient last name	Patient date of birth *(mm/dd/yyyy)* / /

Physician information

Physician first name	Physician last name	National provider identifier

Pharmacy information

Name of pharmacy	Pharmacy national provider identifier	Telephone number *(include area code)* - -	
Pharmacy mailing street address	City	State	ZIP code
Is this an on-site nursing home pharmacy? ☐ Yes ☐ No			

I certify that the medications for which reimbursement is requested were received for use by the patient above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medications received were not for treatment of an on-the-job injury. I recognize reimbursement will be paid directly to me, and assignment of these benefits to a pharmacy or any other party is void.

Signature: ____________________ **Date:** ____________________

Complete the claim information below. All fields are required to process your claim.

Refer to your pharmacy receipt or contact your pharmacy for missing information.

	Date of service *(mm/dd/yyyy)*	**Prescription number** *If submitting a foreign prescription, leave this field blank.*	**Prescription name and strength**	**National drug code (11-digit NDC)** *If submitting a foreign prescription, leave this field blank.*	**Quantity**	**Days' supply**			**Amount paid**
						30-day	90-day	Other *(Specify)*	
1									
2									
3									
4									
5									
6									

Compound prescription

Requirements

- Submit one claim form per compound prescription.
- List **valid** 11-digit NDC number (highest to lowest cost) in the box at right.
- For each NDC number, indicate the metric quantity expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Include **each** ingredient used in the compound prescription.
- Indicate the **total** amount paid by the patient.
- Detailed pharmacy receipts must be provided with this claim form.

COMPOUND PRESCRIPTION ONLY		
Prescription #:		Quantity:
Date of service: / /		Day supply:
Ingredient NDC number	Metric quantity	Ingredient cost
	Amount paid:	