skai BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Claim Form

Important!



- Allow up to 30 days for claims processing and delivery. **For faster review, you can request reimbursement through your Caremark.com account.**
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed. Claims are subject to limitations, exclusions, and provisions of the plan.
- All sections must be filled out. Incomplete submissions will be returned.
- Provide us with the pharmacy receipt or print out.
- Complete one form for each member.

STEP 1 Card Holder/Member Information

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip/Postal Code Country

Member Information

Last Name

First Name MI

Date of Birth Phone Number

Pharmacy Information

Pharmacy Name

Address

City State Zip/Postal Code

REQUIRED: Please check appropriate box for submitting a paper claim.

- ☐ Allergy/Allergen Clinic
- ☐ Pharmacy does not accept insurance
- ☐ Compound
- ☐ No insurance coverage at the time
- ☐ Traveling within the U.S.
- ☐ Natural disaster/emergency
- ☐ Insurance card unavailable
- ☐ Appealing Claim
- ☐ Requesting tiering exception
- ☐ Needed approval first
- ☐ Other–provide reason below

_____

_____

☐ Medicine purchased outside of the U.S.

PLEASE INDICATE:

Country/Region: _____

Currency used: _____

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? ☐ YES ☐ NO

Is the medicine covered under any other group insurance? ☐ YES ☐ NO

If YES, is other coverage:

☐ PRIMARY ☐ SECONDARY

☐ MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

_____

_____

ID#: _____

Pharmacy Information (Cont.)

Phone Number | Is this an on-site nursing home pharmacy? YES NO | NCPDP/NPI

x

Signature of Pharmacist or Representative

Important! A signature is REQUIRED

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits and/or imprisonment.

(New York Members Only) Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(California Members Only) For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x

Signature of Member (REQUIRED) Date

STEP 2 Prescriber's Information

Name: _____

Address: _____

City, State, Zip/Postal Code: _____

Phone: _____

STEP 3 Mail completed forms with receipts to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER–To avoid having to submit a paper claim form:

- Always have your ID card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your ID card.

Comments:

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Required Claim Information

Prescription 1	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's National Provider ID (NPI) Number	Quantity of Drug	Days Supply
Prescription 2	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 3	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 4	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 5	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 6	Rx Number	Drug Name	
	NDC Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply

Allergy Claim Information

Allergy 1

Date of Purchase (MM/DD/YY)	Number of Vials	Charge per treatment for professional immunotherapy in your office. (Cost)
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Charge for preparation of allergenic extract in location other than your office. (Cost)
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total charge for allergenic extract only. (Cost)
Directions		
Ingredients		

Allergy 2

Date of Purchase (MM/DD/YY)	Number of Vials	Charge per treatment for professional immunotherapy in your office. (Cost)
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Charge for preparation of allergenic extract in location other than your office. (Cost)
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total charge for allergenic extract only. (Cost)
Directions		
Ingredients		

Allergy 3

Date of Purchase (MM/DD/YY)	Number of Vials	Charge per treatment for professional immunotherapy in your office. (Cost)
Number of Treatments ☐Single Dose ○Multidose	Days Supply	Charge for preparation of allergenic extract in location other than your office. (Cost)
Vial Contains ☐Single Antigen ○Multiantigen	Administered By ☐Physician ○Nurse ○Self	Total charge for allergenic extract only. (Cost)
Directions		
Ingredients		