MASSACHUSETTS

Prescription Drug Claim Form - Medicare Part D

Instructions for using this form:

1. Present your prescription drug card at the pharmacy to avoid having to submit this drug claim form for reimbursement.
2. If necessary, use this form for prescription claims that were purchased without presenting your card due to an emergency or at a non-participating pharmacy. For consideration of payment, you must send all of the requested information for each claim at the address below. If the information is complete your claim(s) will be processed within 14 days. Your reimbursement request may be denied if you submit incomplete information and we are unable to obtain the information from your pharmacy or physician.
3. **Complete all items in sections (A) and (B)**. Sign the form in the area provided. Enclose original receipts with this form. Be sure your itemized receipts include the following:
   - Pharmacy Name
   - Pharmacy NABP Number
   - Prescription Number
   - Date of Purchase
   - Medicine Name
   - Strength
   - Quantity Dispensed
   - Physician ID Number
   - Total Amount Charged For Each Prescription

   Please make copies for your records.
4. **If your claim is for a compound drug or you are not able to submit original pharmacy receipts, please have your pharmacist or physician complete sections (C) and (D) of this form.**
5. Items not covered under your prescription benefit plan should not be submitted for reimbursement including Durable Medical Equipment. Diabetic supplies requiring a prescription are reimbursable only if covered by your plan.
6. Mail, email or fax completed form to:

Mail: **Blue Cross Blue Shield of Massachusetts, Medicare Advantage, Appeals Coordinator, P.O. Box 55007, Boston, MA 02205**

Email: **MedicareAdvantageRXAppeals@bcbsma.com**

Fax: **1-617-246-8506**

This document is available in other formats. For more information, call 1-800-200-4255, 8:00 a.m. to 8:00 p.m. Eastern Time, seven days a week except April 1 through September 30 when we are open Monday through Friday. TTY users call 711.

Blue Cross and Blue Shield of Massachusetts is a HMO and PPO plan with a Medicare contract. Enrollment in Blue Cross Blue Shield of Massachusetts depends on contract renewal. Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

All beneficiaries must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances. Quantity limitations and restrictions may apply.

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-200-4255 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-200-4255 (TTY: 711).

A. Cardholder - Information		**Today's Date:**	
Cardholder's Name (Last, First, MI)		Cardholder ID Number	
Address		City / State / Zip Code	
		Cardholder's Date of Birth / /	Gender ❑ M ❑ F
Cardholder Telephone Number	Plan Name		
Why was the prescription drug card NOT used for this purchase? Please explain below:			

B. Other Insurance Coverage			
Is cardholder eligible for primary prescription drug coverage from another provider? ❑ Yes ❑ No **If yes, please use that insurance card to complete the fields below. Please also include a copy of the Explanation of Benefits from that provider when submitting this drug claim form.**			
Insured's Name (Last, First, MI)			
Other Insurance Company's Name	Member ID	PCN #	Coverage Effective Date / /

Cardholder Signature: _____ Date:

Reimbursement of submitted claims is subject to your prescription benefit program and not guaranteed. Reimbursement will be according to the parameters of your prescription benefit plan. It will be only for the amount your program would have paid on your behalf. The amount of reimbursement may be significantly lower than the original amount you paid.

Information to be completed by your Pharmacist/Physician: By completing Sections C and D, you certify the information correctly represents the amount paid by the member for the prescriptions dispensed. You acknowledge that all payments related to these prescriptions will be paid to the member.

If more than three (3) prescriptions are being submitted, please complete additional claim form(s).

C. Claim(s) Information					
1. Is this a compound Rx? ❑ Yes ❑ No	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? ❑ Yes ❑	Prescriber Fax Number:				
2. Is this a compound Rx? ❑ Yes ❑ No	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? ❑ Yes ❑	Prescriber Fax Number:				
3. Is this a compound Rx? ❑ Yes ❑ No	Fill Date	Rx Number	Quantity	Days Supply	Strength/Dosage
National Drug Code (NDC)	Medication Name	Charge (including tax)	Prescriber Name	Prescriber ID	
Was this prescription filled in a foreign country? ❑ Yes ❑	Prescriber Fax Number:				

Compounds

Even if you have itemized receipts, the following must be completed by your pharmacist if the prescriptions being submitted for reimbursement are compound medications.

NDC Number	Ingredient	Quantity	Cost
Compounding Fee			

D. Authorization				
National Provider Indicator (NPI) Number	Pharmacy Name			
Pharmacist/Physician Name	Pharmacy/Physician Address	City	State	Zip Code
Physician/Pharmacy Phone Number				
Pharmacist/Physician Signature:				