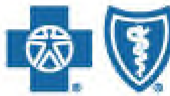

Prescription Drug Claim Form - Medicare Part D

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. You will be contacted should 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 completed form to**: Blue Cross Blue Shield of Massachusetts, Medicare Advantage, Appeals Coordinator, P.O. Box 55007, Boston, MA 02205**

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, January 1 through February 14 and October 1 through December 31. From February 15 through September 30, you can call us 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday. TTY users call 1-800-522-1254.

Blue Cross Blue Shield of Massachusetts is a Medicare Advantage organization with a Medicare contract

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.

<table>
<tr><td colspan="2">A. Cardholder - Information</td><td colspan="3">Today's Date:</td></tr>
<tr><td colspan="2">Cardholder's Name (Last, First, MI)</td><td colspan="3">Cardholder ID Number</td></tr>
<tr><td colspan="2" rowspan="2">Address</td><td>City</td><td>State</td><td>Zip Code</td></tr>
<tr><td colspan="2">Cardholder's Date of Birth
/ /</td><td>Gender
□ M □ F</td></tr>
<tr><td>Cardholder Telephone Number</td><td colspan="4">Plan Name</td></tr>
<tr><td colspan="5">Why was the prescription drug card NOT used for this purchase? Please explain below:</td></tr>
</table>

<table>
<tr><td colspan="4">B. Other Insurance Coverage</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td colspan="4">Insured's Name (Last, First, MI)</td></tr>
<tr><td>Other Insurance Company's Name</td><td>Member ID</td><td>PCN #</td><td>Coverage Effective Date
/ /</td></tr>
</table>

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 □ No	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 □ No	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 □ No	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: