

# Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.  
An incomplete form may delay your reimbursement.



## Member/Subscriber Information *See your BCBS ID card.*

Group No. **B C B S M A N**

Contract/  
Enrollee ID#

**Enter your 9 digit numeric Contract/Enrollee ID# only; do not include the alpha prefix. The Contract/Enrollee ID# is found on your BCBSM ID card.**

Contract/Enrollee Name (First, Last)

Street Address

City

State/Province

Zip/Postal Code

Country

## Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year)

Sex

*Relationship to Plan Member*

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Female | <input type="checkbox"/> 1 Self              | <input type="checkbox"/> 5 Disabled Dependent |
| <input type="checkbox"/> Male   | <input type="checkbox"/> 2 Spouse            | <input type="checkbox"/> 6 Dependent Parent   |
|                                 | <input type="checkbox"/> 3 Eligible Child    | <input type="checkbox"/> 7 Nonspouse Partner  |
|                                 | <input type="checkbox"/> 4 Dependent Student | <input type="checkbox"/> 8 Other              |

## Pharmacy Information

Name of Pharmacy

Street Address

City

State

Zip

Telephone (include area code)

**Is this an on-site nursing home pharmacy?**  Yes  No

## Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (or the patient, if not myself) am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

**X**

Signature of Member

## Claim Receipts

Tape receipts or itemized bills on the back.  
**See back for details.**

Check the appropriate box if any receipts or bills are for a:

**Compound prescription**  
Make sure your pharmacist lists ALL the VALID 11 digit NDC numbers and ingredients and quantities on the receipt or bill.

**Medication purchased outside of the United States**

Please indicate:

Country \_\_\_\_\_

Currency used \_\_\_\_\_

**Allergy medication**

**Coordination of Benefits**

Please indicate:

Primary insurance carrier \_\_\_\_\_

Primary prescription drug program \_\_\_\_\_

## See back for more information

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 and/or imprisonment, or denial of benefits.\*

**Please tape receipts on the back.  
Keep a copy for your records.**



