QMCSO

Claim Form

Alternate Payer or Qualified Medical Child Support – Blue Rx

BlueCross BlueShield of Kansas

www.bcbsks.com

BlueRx[SM]

Section 1

Member Name ______________________________
Last First MI

Identification No. ______________________ Group No. ______________________

Home Address ______________________________
Street City State ZIP Code

Home Phone No. ______________________
Area Code

Section 2

Alternate Payee Information:

☐ Change of Address: If the address above is a different address, please check this box.

Patient Name ______________________ Date of Birth ______________________

Alt. Payee Name ______________________________
Last First MI

Alt. Payee Address ______________________________
Street City State ZIP Code

Alt. Payee Phone No. ______________________
Area Code

Section 3

Date Filled	Prescription Number	Quantity	Days Supply	National Drug Code (NDC)	Form (capsule, tablet ml, gm, etc.)	Amount Charged	Name and Address of Dispensing Pharmacy	Name and Address of Prescribing Physician
1				- -				
2				- -				
3				- -				
4				- -				
5				- -				
6				- -				

I certify the information on this form is correct and that I am claiming benefits only for charges itemized on this form.

Signature of Alt. Payee X ______________________________ **Date** ____/____/____

*An Independent Licensee of the Blue Cross and Blue Shield Association.

Please read instructions on other side.→

General Instructions:

This claim form is for use with a prescription drug contract with Blue Cross and Blue Shield of Kansas. It must be submitted with the Claim Form for Qualified Medical Child Support, form #34-438.

Correct product identification and payment requires the use of a specific 11-digit National Drug Code (NDC) number obtainable from the pharmacist who filled your prescription.

Each line completed on this claim form must be accompanied by a specific itemized billing from the pharmacy that filled the prescription.

Claims must be filed within one (1) year and ninety (90) days of the date the prescription was filled to be eligible for benefits.

Section 1 – Insured Information (required):

Member Name: Enter member's name as it is printed on your identification card.

Identification Number: Enter the number appearing on your identification card.

Home Address: Enter the member's street address, city, state and ZIP code.

Section 2 – Patient Information (required):

Patient Name: Complete as indicated if the patient is someone other than the member.

Section 3 – Claim Information (all fields are required):

Date Filled: The date (month, day, year) your prescription was filled or refilled by the pharmacy.

Prescription Number: The same prescription number printed on your drug label.

Quantity: The number of capsules, tablets, milliliters or grams in the prescription.

Days Supply: The number of days your prescription would last if taken according to directions. A 100-tablet prescription to be taken 3 times each day would last approximately 33 days.

National Drug Code (NDC): Enter the 11-digit drug code number printed on your medicine label by the pharmacy, or obtainable from the pharmacy where your prescription was filled.

Form: Tablet, capsule, milliliters, grams, etc.

Amount Charged: Enter the total amount charged for each prescription.

Name and Address of Dispensing Pharmacy: Enter the name and complete address (including city, state and ZIP code) of the pharmacy where you obtained your medicine.

Name and Address of Prescribing Physician: Enter the name and complete address (including city, state and ZIP code) of the physician who prescribed the medicine.

Don't forget to sign and date your claim form.