

Prescription Drug Claim Form



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Topeka, KS 66629-0001

www.bcbsks.com

Please read instructions on the back of this form.

Member's Information

Member's Name: _____ Member's ID number _____
Last First MI

Member's Address: _____
Street City State ZIP Code

Patient's Information

Patient's Name: _____ Patient's date of birth: _____
Last First MI

Patient's relationship to member: Self Spouse Dependent Other

Claim Information

Date Filled	Prescription Number	Quantity	Days Supply	National Drug Code (NDC)	Form (Capsule, Tablet ml, gm, etc.)	Amount Charged	Amount Paid by Primary	Dispensing Pharmacy	Name and Address of Prescribing Physician	Diagnosis
Total Charge										

If we are the patient's secondary insurance carrier, please make sure the total charge as well as the primary carrier's payment is reflected and/or an explanation of benefits is attached.

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

Signature of member _____ Date: _____

DON'T FORGET TO SIGN AND DATE YOUR CLAIM FORM

Member Information (REQUIRED)

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

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

Address - Enter member's street, city, state and ZIP code.

Patient Information (REQUIRED)

Complete as indicated if the patient is someone other than the member. If same, mark **Self** in relationship.

Claim Information (ALL ARE REQUIRED)

Date Filled - The date your prescription was filled or refilled by the pharmacy, month, day and year.

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) Number - Enter the actual 11 digit National Drug Code (NDC) number placed 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.

Amount Paid by Primary - (ONLY REQUIRED IF) we are the patient's secondary carrier, enter the amount paid by the primary insurance carrier.

Dispensing Pharmacy - Enter the name and complete address of the pharmacy where you obtained your medicine.

Name and Address of Prescribing Physician - Enter the name and address of the physician who prescribed the drug.

Diagnosis - The illness this drug is treating.

General Instructions

This claim form is for use with a Prescription Drug contract, with Blue Cross and Blue Shield of Kansas.

Correct product identification and payment requires the use of 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 who filled the prescription.

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