PremierBlue*

P.O. BOX 3518, TOPEKA, KANSAS 66601-3518

PRESCRIPTION DRUG CLAIM FORM

1. Member's Name ______________________________
   Last | First | Middle Initial

2. Patient's Name ______________________________
   Last | First | Middle Initial

   Group Number ______________ Identification Number ______________

   Sex __________ Relationship to Member ______________ Date of Birth ______________
   (Self, Spouse, Son, Daughter) (MO, DAY, YEAR)

   Home Address ______________________________
   Street | City

   ____
   State | Zip Code | Telephone Number

   Primary Care Physician's Name ______________________________

3. Summary of Itemized Bills. In addition, copies of all bills must accompany this form.

Name of Pharmacy	Prescribing Physician	Date of Purchase	Name, Form and Strength or NDC Number of Drug	Amount	Diagnosis

4. I certify the information on this form is correct and that I am claiming benefits only for charges incurred by the patient named on this form.

____
Signature of Member | Date

INSTRUCTIONS

1. Complete item 1 using information on the member for whom this claim is being submitted. USE A SEPARATE FORM FOR EACH PATIENT.

2. Itemize your bills in Item 3 AND attach copies of all bills. Bills must include the following:
   - Name of Pharmacy
   - Name of Patient
   - Date of Purchase
   - Prescription Number
   - Name, Form and Strength or NDC Number
   - Charge for each Prescription

3. Sign and date the completed form - Item 4.

4. Send this form together with itemized bills and supporting materials to:
   PremierBlue
   P.O. BOX 3518
   TOPEKA, KANSAS 66601-3518

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