Arkansas BlueCross BlueShield | BlueAdvantage Administrators of Arkansas | Health Advantage | Octave BlueCross BlueShield

Prescription Reimbursement Claim Form

Important!

- Always allow up to 30 days from the time you receive the response to allow for claims processing and delivery.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed and other contractor will review the claims subject to limitations, exclusions and provisions of the plan.

STEP 1

Card Holder/Member Information

This section must be fully completed to ensure proper reimbursement of your claim.

Card Holder Information

Identification Number (refer to your ID card)

Group Number/Group Name

Last Name

First Name MI

Address

Address 2

City

State Zip/Postal Code Country

Member Information–Use a separate claim form for each member

Last Name

First Name MI

Date of Birth Phone Number

Pharmacy Information

Pharmacy Name

Address

City State Zip/Postal Code

REQUIRED: Please check appropriate box for submitting a paper claim. Claim will be returned if incomplete. (Tape receipts and/or itemized bills on another sheet of paper)

Reason I am filing this form is:

- ☑ Allergy/Allergen Clinic
- ☑ Pharmacy does not accept insurance
- ☑ Compound
- ☑ No insurance coverage at the time
- ☑ Other–provide reason below

_____

_____

☑ **Medication purchased outside of the United States** (Tape receipts and/or itemized bills on another sheet of paper)

PLEASE INDICATE:

Country/Region: _____

Currency used: _____

Other Insurance Information

Coordination of Benefits (COB)

Are any of these medicines being taken for an on-the-job injury? ☑ YES ☐ NO

Is the medicine covered under any other group insurance? ☐ YES ☑ NO

If YES, is other coverage:

☐ PRIMARY ☑ SECONDARY

☐ MEDICARE PART D

If other coverage is PRIMARY, include the Explanation of Benefits (EOB) with this form.

Name of Insurance Company:

_____

_____

ID#: _____

continued

Pharmacy Information (Cont.)

Phone Number

Is this an on-site nursing home pharmacy? **YES** ☑ **NO** ☐

NCPDP/NPI

x

Signature of Pharmacist or Representative

Important! A signature is REQUIRED

NOTICE

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, denial of benefits and/or imprisonment.

(New York Members Only) Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

x

Signature of Member (REQUIRED) **Date**

STEP 2 Submission Requirements

You MUST include all original "pharmacy" receipts in order for your claim to process. "Cash register" receipts will ONLY be accepted for diabetes supplies. The minimum information that must be included on your pharmacy receipts is listed below:

- Member Name
- Prescription Number
- Medicine NDC Number
- Date of Fill
- Metric Quantity
- Total Charge
- Days Supply for your prescription (you need to ask your pharmacist for this "Day Supply" information)
- Pharmacy Name and Address or Pharmacy NCPDP Number

Number of prescriptions you are submitting for reimbursement: _____

Prescribing physician's national provider identification (NPI) number: _____

Prescribing physician's information (all fields required):

Name: _____

Address: _____

City, State, Zip/Postal Code: _____

Phone: _____

Additional comments:

STEP 3 Mail completed forms with receipts to:

CVS Caremark
P.O. Box 52136
Phoenix, Arizona 85072-2136

IMPORTANT REMINDER—To avoid having to submit a paper claim form:

- Always have your ID card available at time of purchase.
- Always use pharmacies within your network.
- Use medication from your formulary list.
- If problems are encountered at the pharmacy, call the number on the back of your ID card.

Prescription Claim Information

Prescription 1	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 2	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 3	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 4	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 5	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply
Prescription 6	Prescription (Rx) Number	Drug Name	
	National Drug Code (NDC) Number	Date Filled (MM/DD/YY)	Total Paid (Cost)
	Prescriber's NPI Number	Quantity of Drug	Days Supply

Allergy Claim Information

Allergy 1

Date of Purchase (MM/DD/YY)

Number of Vials

Charge per treatment for professional immunotherapy in your office. (Cost)

Number of Treatments

Days Supply

☐ Single Dose ☑ Multidose

Charge for preparation of allergenic extract in location other than your office. (Cost)

Vial Contains
☑ Single Antigen
☐ Multiantigen

Administered By
☐ Physician
☐ Nurse
☑ Self

Total charge for allergenic extract only. (Cost)

Directions

Ingredients

Allergy 2

Date of Purchase (MM/DD/YY)

Number of Vials

Charge per treatment for professional immunotherapy in your office. (Cost)

Number of Treatments

Days Supply

☐ Single Dose ☑ Multidose

Charge for preparation of allergenic extract in location other than your office. (Cost)

Vial Contains
☐ Single Antigen
☑ Multiantigen

Administered By
☐ Physician
☐ Nurse
☑ Self

Total charge for allergenic extract only. (Cost)

Directions

Ingredients

Allergy 3

Date of Purchase (MM/DD/YY)

Number of Vials

Charge per treatment for professional immunotherapy in your office. (Cost)

Number of Treatments

Days Supply

☐ Single Dose ☑ Multidose

Charge for preparation of allergenic extract in location other than your office. (Cost)

Vial Contains
☐ Single Antigen
☑ Multiantigen

Administered By
☐ Physician
☐ Nurse
☑ Self

Total charge for allergenic extract only. (Cost)

Directions

Ingredients