Enrollee Prescription Drug Claim Form

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

REASON FOR REIMBURSEMENT

Thank you for being a Blue Cross® Blue Shield® of Arizona member. Please use this claim form to request reimbursement of covered expenses. You may select one of the reasons below to tell us more about your request. Note that the use of a claim form, such as this Enrollee Prescription Drug Claim Form, is not required to receive a reimbursement.

- ☐ I did not use my prescription drug ID card
- ☐ Non-participating pharmacy *(Please explain)* _____
- ☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier
- ☐ Discount Card was used
- ☐ I was retroactively enrolled with the plan
- ☐ I was administered a Part D vaccine in my physician's office or clinic (cost for vaccine and administration fees must be listed separately)
- ☐ Other/explanation: _____

ENROLLEE INFORMATION

ID number (on the front of your prescription drug ID card): _____

Group Number (on the front of your prescription drug ID card): _____

Enrollee name: _____

Enrollee birth date: Month _____ Day _____ Year _____ | Enrollee sex: ☐ Male ☐ Female

ENROLLEE CERTIFICATION

I represent that the enrollee information entered on this form is correct, that the enrollee named is eligible for the benefits and that the enrollee has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

WARNING – Any person who knowingly with intent to, or assist with intent to, injure, defraud, or deceive an insurance company, files a claim containing false, incomplete or misleading information may be prosecuted under state law and subject to civil fines and criminal penalties.

Enrollee signature: _____ Date: _____

Daytime phone number: _____

PRESCRIPTION INFORMATION

Use this section for brand and generic medication refund requests.
(See the next section for compound prescription refund requests.)

1)	Date filled	Rx number	Quantity	Day supply
	Drug name and strength		11-digit NDC number	Amount paid $
	Prescribing doctor's name			Physician NPI
	Pharmacy name, address and phone number			Pharmacy NPI
2)	Date filled	Rx number	Quantity	Day supply
	Drug name and strength		11-digit NDC number	Amount paid $
	Prescribing doctor's name			Physician NPI
	Pharmacy name, address and phone number			Pharmacy NPI

COMPOUND PRESCRIPTION INFORMATION

This section is only for multi-ingredient compound prescription refund requests. The drug information should be completed by the dispensing pharmacy or the pharmacy can provide a Universal Claim Form. A pharmacy-generated receipt should accompany each request.

Date filled	Rx number	Dispensing fee $	Total amount paid $
Prescribing doctor's name			Doctor's phone number
Pharmacy name and address			Pharmacy NABP

Ingredient	11-digit NDC	Drug name	Metric quantity	Amount paid
1				
2				
3				
4				
5				

Pharmacist signature and date: _____

INSTRUCTIONS

1. Fully complete all sections of this form. Submit a separate form for each request.
2. Sign and date the Enrollee Certification statement in the area provided.
3. If you do not have detailed prescription receipts for each medication related to your request, you can ask your pharmacist for a replacement receipt or a patient printout.
4. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement.
5. If you filled a compound medication, your pharmacy should fill out the designated section of this form. If your prescription is not a compound medication, there is no need to complete the compound prescription section.
6. Claims missing information may be denied. Remember to send detailed prescription receipts or a pharmacy printout. Please note that cash register receipts alone are not acceptable.
7. If you need help completing this form, contact your pharmacist.
8. Make a copy of your prescription receipts. Keep a copy for your records.
9. Please mail your request to:

MedImpact Healthcare Systems, Inc.
P.O. Box 509108
San Diego, CA 92150-9108
Fax: 858-549-1569
E-mail: Claims@Medimpact.com

If you have questions, we'd be happy to help. Please call Member Services at 480-937-0409 (in Arizona) or toll-free at 1-800-446-8331. TTY users should call 711. We are here 8:00 a.m. to 8:00 p.m., Monday through Friday from April 1 to September 30; and 7 days a week from October 1 to March 31.

Comuníquese con nuestro Departamento de Servicio al Cliente al 480-937-0409 (en Arizona) o al número gratuito 1-800-446-8331 para obtener información adicional. Los usuarios de TTY deben llamar al 711. El horario de atención es de 8:00 a.m. a 8:00 p.m., lunes a viernes desde el 1 de abril hasta el 30 de septiembre; y los 7 días de la semana desde el 1 de octubre hasta el 31 de marzo.