

Drug Claim Form



ND

Member information (See other side for instructions)

ID number _____

Group number _____

Date of birth ____ / ____ / ____ Male Female

Name (First, Last) _____

Street address _____

City _____ State _____ Zip _____

Member's relationship to primary cardholder:

Self Spouse/Domestic partner Dependent/Child

I certify that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the medicine(s) listed
- These benefits have not been assigned; any further assignment is void
- I give my permission to share the information on this form with Prime Therapeutics LLC

X

Member or legal representative signature _____

Is this medicine for an on-the-job-injury? Yes No

Do you have other insurance for this prescription medicine? Yes No

If yes, what is the other insurance company's name? _____

Cardholder information (primary cardholder)

Name (First, Last) _____

OTC COVID test kit claim

To be reimbursed for a COVID home test kit, please attach itemized pharmacy receipts to the back of this form. Please enter the NDC or UPC number from the cash register receipt. All information below is required.

NDC or UPC number _____

Date purchased _____ Quantity of tests _____

Test kit cost \$ _____

IMPORTANT: You must sign the form, confirming that the test kit was not used for testing required by your employer, or for return to work, travel, admittance to a recreational event or resale.

NOTE: Claims are subject to your plan's limits, exclusions and provisions.

Signature _____

Pharmacy information

Pharmacy name _____

Pharmacy address _____

City _____ State _____ Zip _____

Prescription (Rx) claim information

Was this prescription medicine purchased outside the U.S.? Yes No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach itemized pharmacy receipts to the back of this form.

Claims are subject to your plan's limits, exclusions and provisions.

1 Rx number _____

Date filled _____

Quantity _____ Days' supply _____

Name of medicine _____

NDC number _____

(Your pharmacist can provide the national drug code (NDC) and national provider identifier NPI numbers.)

Physician

NPI number _____

(Does not apply for COVID home tests)

Prescription cost \$ _____

Balance due \$ _____

2 Rx number _____

Date filled _____

Quantity _____ Days' supply _____

Name of medicine _____

NDC number _____

(Your pharmacist can provide the national drug code (NDC) and national provider identifier NPI numbers.)

Physician

NPI number _____

(Does not apply for COVID home tests)

Prescription cost \$ _____

Balance due \$ _____

Instructions

1. Use a separate claim form for each member and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
2. Attach original itemized pharmacy receipts provided with your Rx prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. If you are submitting for reimbursement of OTC COVID-19 Test Kit(s), fill out Member Information, Cardholder Information and the OTC COVID test kit claim information sections. Attach your register receipt to this form with the kit price visible.

Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800.821.4795

4. Send this completed form with itemized receipts to:

Prime Therapeutics
Mail route BCBSND
PO 25136
Lehigh Valley, PA 18002-5136

EXAMPLE

Rx number

Date filled

Quantity Days' supply

Name of medicine Drug Name

NDC number
(Your pharmacist can provide the national drug code (NDC) and national provider identifier NPI numbers.)

Physician NPI number
(Does not apply for COVID home tests)

Prescription cost \$

Balance due \$

Is this prescription claim for a compound medicine?

Yes No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan 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 health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.