CAA: Self-Funded Prescription Drug Data Collection (RxDC)

Please send completed form back to your Blue Cross Blue Shield of North Dakota representative.

Fields with an * are required for submission.

Client Information

Client Name*
Client Number*
Health Plan Name*

Plan Information

Employee and Employer Contribution percentage to be outlined below. Employee and employer contribution should equal 100% or total premium for each tier level.

Tier Level	Employee Contribution % or $	Employer Contribution % or $	Premium Charged By Tier
Individual*			
Employee & Child			
Employee & Children			
Employee & Spouse			
Family			

☐ Select if you apply 100% of the single premium cost towards all tier levels

OR

If percentages vary by age groups, please note that in the comment section below. Otherwise, please fill out the total dollars for the previous calendar year.

Total annual premiums contributed by your employer group*	$
Total annual premiums contributed by your employees *	$

Note: Please remember this is for all premiums in the previous calendar year. If you had any contribution changes mid-year, please account for those below and note the date change.

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