MEMBER SUBMITTED CLAIM FORM PHARMACY SERVICES

NOTE: Incomplete claim forms will be returned and will delay the processing of the claim.

Member Instructions:

1. Complete section 1
2. Sign form at end of section 1
3. Request your pharmacist or pharmacy supplier complete sections 2a, 2b and 2c
4. Submit complete form (sections 1 and 2) along with any receipts, itemized statements and proof of payment
5. Retain copies of all documents for your records

Physician/Provider/Supplier Instructions:

1. Complete section 2a, 2b and 2c.
2. Sign and return to patient or Blue Cross Blue Shield of North Dakota (BCBSND)

Member Submitted Prescription Drug Claim Form

4510 13th Avenue South • Fargo, North Dakota 58121

Patient Information — SECTION 1

Member ID

Patient Name (First, Last)

Street Address

City State ZIP

Date of Birth / / ☐ Male ☐ Female

I certify that the information is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein and authorize release of all information contained on this claim form to Blue Cross Blue Shield North Dakota.

Patient/Subscriber/Member or Legal Representative Signature

Is this a medication for an on-the-job injury? ☐ Yes ☐ No

Do you have other insurance for prescription medications? ☐ Yes ☐ No

If yes, please provide Name of other Insurance:

Policy Number:

Please include any pharmacy receipts related to this claim with this form.

Pharmacy Information — SECTION 2a

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information — SECTION 2b

Original pharmacy receipts are required. Please submit receipts, itemized statements and proof of payment

Was this prescription medication purchased outside the U.S.A.? ☐ Yes ☐ No

All fields below must be completed.
(Example on back of form.)
Call your pharmacist if you need assistance.

1 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescribing Physician NPI Number

Prescription Cost $.

Amount Paid By Member $.

2 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescribing Physician NPI Number

Prescription Cost $.

Amount Paid By Member $.

3 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

Prescribing Physician NPI Number

Prescription Cost $.

Amount Paid By Member $.

SECTION 2c

EXAMPLE

of how to complete the Prescription Drug Claim Form

Rx Number 0 0 0 0 0 6 0 1 1 4 8 1

Date Filled 0 1 / 1 2 / 1 3

Quantity 30 Day Supply 3 0

Name of Medication "Drug Name"

NDC Number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the NDC number identifying the drug.)

Prescribing Physician NPI Number 9 2 1 5 2 4 1 1 6 3

Prescription Cost $ 2 0 5 . 1 4

Amount Paid By Member $ 5 0 . 0 0

Is this prescription claim for a compound medication?

☐ Yes ☐ No

Note: If yes, make sure your pharmacist completes the information below.

Compound Information:

If a compound prescription, please enter all information per drug used.

Compound Prescriptions

For pharmacy use only

Rx #	NDC Number	Drug Ingredient	Quantity	Charge