Print Form

Mail to: BCBSND
Attn: Pharmacy Department
4510 13th Ave S
Fargo, ND 58121

Reimbursement for Provider Dispensed Take Home Drugs

A clinic representative must complete this form to submit charges for take home drugs dispensed in a provider's office.

Benefit Plan Number: _____

Insured's Name: _____ _____
(Last) (First)

Patient Name: _____ _____ Date of Birth: _____ Sex: ☐ M ☐ F
(Last) (First) (MM/DD/YYYY)

Prescribing Provider: _____ NPI: _____

Clinic Name: _____ Address: _____
(Street, City, State, Zip Code)

Fill Date: _____ Prescription Number: _____

Drug Name: _____ National Drug Code (NDC): _____

Strength: _____ Quantity: _____ Days Supply: _____

Prescription Charge: $ _____

Amount Paid by Patient: $ _____

Clinic Representative: _____
(I certifiy that the above information is true, accurate and complete.)

Phone Number: _____ Date: _____