

# Prescription Drug Claim Form



BlueCross BlueShield  
of Montana

## 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
- 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)

**Why are you submitting this Prescription Drug Claim Form?**  
(check one)

- Did not have my pharmacy card with me when I bought this prescription
- Have not received my pharmacy card
- Picked up my medicine from a non-network pharmacy
- My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)
- Other (please explain) \_\_\_\_\_

## Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

**X**

Pharmacist signature

## 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.

**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

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

Prescription cost \$  .

Balance due \$  .

**Instructions**

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
2. Attach original itemized pharmacy receipts provided with your 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)

**Questions?**

- You can call the number on the back of your member ID card
  - Your pharmacist may call 800.821.4795
3. Keep a copy of this form and pharmacy receipts for your records. Send the original form and pharmacy receipts to:

Prime Therapeutics  
 PO Box 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

Total prescription charge \$  .

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

Rx 1	Rx 2
<p><b>Attach original itemized pharmacy receipts here</b></p> <p>All required information must be visible (see step 2 above).</p> <p>Keep a copy of this form and your receipt(s) for your records.</p>	<p><b>Attach original itemized pharmacy receipts here</b></p> <p>All required information must be visible (see step 2 above).</p> <p>Keep a copy of this form and your receipt(s) for your records.</p>

**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.

Blue Cross and Blue Shield of Montana is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.



If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-258-8471.

العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-258-8471.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-258-8471。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-258-8471.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-258-8471 an.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-258-8471.
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報入手したりすることができます。料金はかかりません。通訳とお話される場合、855-258-8471までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-258-8471로 전화하십시오.
Diné Navajo	T'áá ní, éí doodago ła'da biká anánlwo'ígíí, na'idíłkídgo, ts'ídá bee ná ahóótí'i' t'áá níík'e níká a'doolwoł dóó bína'idíłkídígíí bee níł hodoonih. Ata'dahalne'ígíí bich'i' hodiílnih kwe'é 855-258-8471.
Norsk Norwegian	Hvis du, eller noen du hjelper, har spørsmål, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 855-258-8471.
Pennsilfaanisch Deutsch Pennsylvanian- Dutch	Wann du, odder ebber as du an helfe bischt, Questions hoscht, hoscht du's Recht fer Hilf un Information griege in dei eegni Schprooch as nix koschte zellt. Wann du mit en Interpreter schwetze wettscht, kannscht du 855-258-8471 uffrufe.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-258-8471.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-258-8471.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-258-8471.
ไทย Thai	หากคุณ หรือคนที่คุณกำลังช่วยเหลือมีข้อสงสัยใด ๆ คุณมีสิทธิที่จะได้รับความช่วยเหลือ และข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่ามโดยติดต่อที่หมายเลข 855-258-8471.
Українська Ukrainian	Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання, у Вас є право отримати безкоштовну допомогу та інформацію Вашою рідною мовою. Щоб зв'язатись з перекладачем, зателефонуйте за номером 855-258-8471.
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 855-258-8471.

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>