BlueCross BlueShield of South Carolina

www.SouthCarolinaBlues.com

Prescription Drug Claim Form

PART ONE: To Be Filled Out By You

Date Submitted: ____/____/____ (MM / DD / YY)

MEMBER NUMBER

MEMBER NAME

STREET ADDRESS

CITY STATE ZIP

( ) DAYTIME TELEPHONE

PATIENT'S NAME (FIRST AND LAST)

/ / PATIENT'S DATE OF BIRTH (MM/DD/YY)

PATIENT IS: ☐ MALE ☐ FEMALE

☐ MEMBER ☐ SPOUSE ☐ CHILD

☐ STUDENT *A separate form must be submitted for each member.*

☐ Check if coverage was provided by another insurance company. (Attach EOB)

The undersigned certifies that the medication described hereon was received by the undersigned for the party named below who is eligible for drug benefits, and that such medication is not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's member number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Pharmacy Information (Affix Computer Receipt For Each Prescription)

NUMBER OF PRESCRIPTIONS (Rx) ATTACHED: _____

PHARMACY NAME ADDRESS **PHARMACY ACCOUNT NUMBER**

CITY STATE ZIP ( ) PHARMACY TELEPHONE

Rx1

TAPE RECEIPT: *NO STAPLES*

The receipts must contain the following information:

- Date Prescription Filled
- Name and Address of Pharmacy
- NDC Number
- Name of Drug and Strength
- Quantity
- Days Supply
- Prescription (Rx) Number
- Amount Paid

Rx2

TAPE RECEIPT: *NO STAPLES*

Rx3

TAPE RECEIPT: *NO STAPLES*

Rx4

TAPE RECEIPT: *NO STAPLES*

DIABETIC AND/OR OSTOMY SUPPLIES

Ask your pharmacist to submit these just like prescription items. You'll be able to enjoy discounts where applicable and all necessary information for processing will be on your receipt(s).

COMPOUNDS

If any of the above Rx's are compounds, ask your pharmacist to list all the ingredients and quantities.

HELPFUL HINTS

Use this form for the following programs:

- Blue Rx℠ Member claims
- DrugCard Member claims where the member forgets to show his ID Card or uses a non-participating pharmacy.

DO's

Go to a participating pharmacy.

Show your ID Card.

Use a separate form for each family member.

Completely fill out Part One of the claim form.

Attach drug receipt(s). The receipts must contain the following information:

- Date prescription filled
- Name and Address of Pharmacy
- NDC Number
- Name of Drug and Strength
- Quantity
- Days Supply
- Prescription (Rx) Number
- Amount Paid

DON'Ts

Don't forget to show your ID Card.

Don't attach more than one family member's receipts to one claim form. Use a separate form for each family member.

Don't forget to attach drug receipt(s).

Don't send your physician bills to the Phoenix address.

If you have any questions about completing this form, call 1-888-963-7290.

Mail your claim to:

BlueCross BlueShield of South Carolina
c/o Caremark
P.O. Box 52059
Phoenix, AZ 85072-2059
