Prescription Drug Claim Form

BlueCross BlueShield of Texas

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
- These benefits have not been assigned; any further assignment is void
- 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)

*If your plan has elected to cover COVID-19 Home Test Kits, please use this form to be reimbursed. Please attach the itemized pharmacy receipt and submit to the address on the back of this form. Cash register receipts will **not** be accepted. There is a limit of 8 At-Home Rapid tests per 30 days.

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Pharmacy NPI number

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.

Claims are subject to your plan's limits, exclusions and provisions.

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 and prescription. All information provided on or attached to this claim form must be for the same person/prescription.
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
- Prescription cost
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)
- Pharmacy NPI number

3. Send this completed form with itemized receipts to:

   Prime Therapeutics Commercial
   PO 25136
   Lehigh Valley, PA 18002-5136

Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800-633-6196

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 2 3

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

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

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number 0 1 2 3 4 5 6 7 8 9

Prescription cost $ 2 0 5 . 1 4

Balance due $ 2 0 5 . 1 4

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 Receipts

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

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

BlueCross BlueShield of Texas

Pharmacy PPO Out-of-pocket Expense Credit Instructions

For member payments made directly to a pharmacy who does not file an insurance claim.

What is it?

When you use insurance to pay for health care, the cost you pay applies to your deductible and/or out-of-pocket maximum.

A new Texas law lets you get credit toward your in-network deductible or out-of-pocket maximum for health care costs in certain situations. **This applies when you pay the pharmacy directly and do not use your insurance.**

- This helps make sure that all your covered pharmacy costs apply to your in-network deductible and out-of-pocket maximum, even when insurance is not used.

Who can claim it?

If you have an Individual/Family, Student or Group PPO Health plan that is regulated by the Texas Department of Insurance (TDI)*, you may be able to submit a claim for PPO Out-of-pocket Expense Credit.

All of the following must be true:

- You paid a pharmacy for a service that's covered by your health plan.
- The pharmacy has not submitted a claim to Prime Therapeutics for the same service.
- The amount you paid the pharmacy is **less than the average discounted rate** that Prime normally pays a pharmacy who is in your plan's network for the covered prescription drug.

How does it work?

Step 1: You visit a pharmacy and agree on a cost with them for your prescription drug.

Step 2: You submit a completed prescription drug claim form with an itemized pharmacy receipt.

Step 3: Prime reviews your claim and checks the amount you paid to make sure it's less than the average discounted rate they would pay a pharmacy who is in your plan's network for the same prescription drug.

Step 4: Your in-network deductible and out-of-pocket maximum amounts may be credited, if needed.

How do I submit a claim?

You can print and mail the completed prescription drug claim form with the itemized pharmacy receipt to:

Prime Therapeutics Commercial
PO Box 25136
Lehigh Valley, PA 18002-5136

What if I have questions?

For help with this form, please call the Customer Service number on your ID card.

*To see if this applies to your plan, look for the TDI symbol on your ID card.

Prime Therapeutics is an independent company contracted by BCBSTX to provide pharmacy benefit management and related other services. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics, LLC.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

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 855-710-6984. 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, sexual orientation, health status or disability. 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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St., 35th Floor	TTY/TDD:	855-661-6965
Chicago, IL 60601	Fax:	855-661-6960

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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilnį.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.