BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

Point-of-Sale Participating Pharmacy
PRESCRIPTION DRUG CLAIM

Use this form for filing Point-of-Sale Drugs from a Participating Pharmacy
* * * IMPORTANT: Please Read The Instructions On The Back Of This Form * * *

Section I. PATIENT/CONTRACT HOLDER INFORMATION

Patient's Name (Last Name, First Name, Middle Initial)	Patient's Birthdate (M M D D C C Y Y)	Sex M F	Contract Holder's Contract Number	Group #

Patient's Address (No., Street)

City | State | Zip Code | Telephone (Include Area Code) ( )

Patient's Relationship To Contract Holder: Self ☐ Child ☐ Spouse ☐ Other ☐

Was Condition Related To Patient's Employment? Yes ☐ No ☐

Contract Holder's Name (Last Name, First Name, MIddle Initial)

Contract Holder's Address

City | State | Zip Code | Telephone (Include Area Code) ( )

Contract Holder Certification: I certify all information provided on this form to be true and correct to the best of my knowledge.

Signature Of Contract Holder _____ Date Signed _____

Section II. OTHER INSURANCE INFORMATION

Is the patient covered by other health insurance? Yes ☐ No ☐ If yes, complete the following:	Policy Or Contract Number	Name of Policy Holder	Effective Date

Name and Address of Other Insurance Carrier:

PLEASE ATTACH A COPY OF THE OTHER INSURER'S BENEFIT PAYMENT NOTICE.

Section III. PRESCRIPTION DRUGS

Please see back page for instructions. It is not necessary to attach receipts if this form is filled out correctly.

Print Numbers Carefully As Shown

0 1 2 3 4 5 6 7 8 9

	Claim Authorization Number	Date Filled (M M D D C C Y Y)	Amount Charged $	Prescription Number (Rx#)
1				
2				
3				
4				
5				

INSTRUCTIONS

Remember to always show your Blue Cross and Blue Shield ID card and ask for the Claim Authorization Number when purchasing a prescription drug.

Please read these instructions carefully before entering your prescription drug claim information on the other side. Claims without the required information could be delayed or returned to you.

USE THIS FORM ONLY FOR DRUGS PURCHASED AT A PARTICIPATING PHARMACY

1. Please use a separate form for each patient. You can file up to 5 prescriptions for the same patient on one form.
2. Use a black pen to fill out the form. Do not use a pencil.
3. Write in designated areas only. Where boxes are provided, please print only one character or number per box. Please do not print outside of the boxes.
4. Complete all information in Sections I and II. Please note:
   - The Contract Holder's ID number and patient information must be valid.
   - The Contract Holder must sign this claim form.
5. Complete the information in Section III or attach pharmacy receipts.
   - The receipt provided by your Pharmacist should provide the following:
     - Claim Authorization Number
     - Date filled
     - Amount Charged
     - Prescription Number

   The Claim Authorization Number and Prescription Number fields may contain more boxes than are necessary.

   Do not attach prescription receipts if you complete this form in its entirety.
6. Mail this claim form to the address shown below:

Blue Cross and Blue Shield of Alabama
Attention: Prescription Drug Claims
P.O. Box 830280
Birmingham, Alabama 35283-0280