INSTRUCTIONS FOR COMPLETING THE PRESCRIPTION DRUG PROGRAM CLAIM FORM

ONE PHARMACY AND ONE PATIENT PER CLAIM FORM

I. SUBSCRIBER AND PATIENT INFORMATION - This section must be filled out in its entirety for claims to be processed. The Contract Number can be found on the subscriber's Blue Cross Blue Shield of Florida Identification Card.

II. PATIENT INFORMATION - This section must be filled out in its entirety for claims to be processed.

III. PHARMACY INFORMATION - This section need only be completed when a receipt containing the requested information is not attached. The Pharmacy NABP number is a unique ID number assigned to each pharmacy, and is required for claims processing. If this number is not found on the subscriber's receipt, it may be obtained from the pharmacy.

IF NO RECEIPT(S) ARE ATTACHED, THE PHARMACIST MUST SIGN THE CLAIM FORM AND THE PRESCRIPTION INFORMATION SECTION MUST BE COMPLETED IN ORDER FOR THE CLAIM TO BE PROCESSED.

IV. PRESCRIPTION INFORMATION - When a non-participating pharmacy is used, you must attach the receipt(s) provided or obtain this information from the pharmacist. The receipt(s) must be attached.

V. SUBSCRIBER CERTIFICATION - The subscriber must sign the Subscriber Certification section.

MAIL COMPLETED CLAIM TO: Blue Cross and Blue Shield of Florida
P. O. Box 1798
Jacksonville, FL 32202

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

PRESCRIPTION DRUG PROGRAM SUBSCRIBER CLAIM FORM

SEND COMPLETED FORM TO:

BLUE CROSS AND BLUE SHIELD OF FLORIDA
P.O. BOX 1798
JACKSONVILLE, FL 32202

Instructions

(See back of form for detailed instructions)

1. Sections I and II - Complete sections in their entirety.
2. Sections III and IV - Only complete when receipts are not attached.
3. Section V - Be sure to sign.

I. SUBSCRIBER AND PATIENT INFORMATION (MUST BE COMPLETED)

PATIENT NAME LAST FIRST INITIAL | SUBSCRIBER NAME LAST FIRST INITIAL

SUBSCRIBER ADDRESS Street City State Zip

Subscriber Contract Number →

II. PATIENT INFORMATION (MUST BE COMPLETED)

DATE OF BIRTH			PLEASE CHECK APPROPRIATE BOXES	SEX		RELATION TO SUBSCRIBER (Check One)			
MO	DAY	YR	→	M	F	SUBSCRIBER	SPOUSE	CHILD	OTHER

Was condition related to an accident? ☐ Yes ☐ No Accident Date ___/___/___

If yes, was it related to: ☐ Auto Accident ☐ Worker's Comp ☐ Other

Is other insurance applicable to charge? ☐ Yes ☐ No

If yes, complete the information below, and attach explanation of benefits.

Other Carrier Name _____ Policy # _____

Name Of Subscriber _____ Amount Paid By Other Insurance $ _____

III. PHARMACY INFORMATION

PHARMACY NAME _____ PHONE ( )

STREET _____ CITY, STATE, ZIP _____

PHARMACY NABP# _____ X _____

Authorized Pharmacy Representative (If no receipts attached)

IV. PRESCRIPTION INFORMATION

DATE RX FILLED			RX NUMBER	NEW or REFILL	QUANTITY	DAYS SUPPLY	NATIONAL DRUG CODE (NDC)	PRESCRIBING PHYSICIAN	AMOUNT PAID
MO	DAY	YR							
				☐ N ☐ R					
				☐ N ☐ R					
				☐ N ☐ R					
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V. SUBSCRIBER CERTIFICATION

I certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge:

SUBSCRIBER SIGNATURE _____ Date ___/___/___

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FORM NO. BCBS 13177-695 SR

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