Prescription Drug Claim Form

Blue Advantage® PART D

CONTRACT HOLDER

Contract Number	Last Name	First Name	Middle Initial
Telephone Number	City	State	Zip Code
Does Contract Holder have other Insurance? ☐ Yes ☐ No	If YES; Name of the Other Insurance Company		
Other Insurance Coverage Effective Date:	Please attach a copy of of the other insurer's benefit payment notice.	Other Insurance Contract Number	
Address of Insurance Company	City	State	Zip Code

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

_____ _____

Signature of the Card Holder Date Signed

PRESCRIPTION DRUGS

- Complete ALL items below. In most cases, information requested will be on the pharmacy receipt—Ask your pharmacist for the information if it is not on the receipt.
- Attach original receipt OR have the pharmacist sign this form.

1.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Diagnosis	National Drug Code		Drug Name, Strength, Form	
2.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Diagnosis	National Drug Code		Drug Name, Strength, Form	
3.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Diagnosis	National Drug Code		Drug Name, Strength, Form	
4.	Prescription Number (Rx#)	Date Filled	Amount Charged	Quantity	Days Supply
	Diagnosis	National Drug Code		Drug Name, Strength, Form	

CONTINUED →

PRESCRIPTION DRUGS

Pharmacy Name	Pharmacy/NABP Number	Telephone Number	
Street Address	City	State	Zip
I certify that the prescriptions listed above are legend drugs which require a prescription and must be dispensed by a Registered Pharmacist. I further certify that they were ordered by the Patients attending Physician for his/her use.			
_____ Signature of Registered Pharmacist		_____ Date Signed	

Filing Your Claim is Easy if you Follow These Instructions:

- Use a separate claim form for each pharmacy.
- Complete the top portion—Contract Holder Information completely. We prefer that you use black ink.
- Make sure you sign this form in the Contract Holder's Certification space.
- You may need help from your pharmacist in completing the lower portion of this claim form regarding specific information about the prescription(s). Often, items such as the NDC Number, Manufacturer, Drug Name, Strength, Form, Quantity and days supply will be on the pharmacy receipt. Your pharmacist will be able to tell you how to determine the information that is abbreviated. If the information is not on the pharmacy receipt, ask the pharmacist for it.
- Attach original pharmacy receipts for each prescription that include the following information:

  — Date of Purchase
  — Prescription Number
  — Charge
  — Patient's Name
  — Name, Address and Phone Number of Pharmacy
  — Name and Address of Prescribing Physician
  — Drug Name and NDC Number

- If you attach the original pharmacy receipts you **do not** have to have the **pharmacist's signature**.

- Mail this claim form to the address shown below:

Blue Cross and Blue Shield of Alabama
Attention: Blue Advantage/Prescription Drug Claims
P.O. Box 995
Birmingham, Alabama 35298-0001

BlueCross BlueShield of Alabama