



An Independent Licensee of the Blue Cross and Blue Shield Association

Prescription Reimbursement Claim Form Comprehensive Major Medical (CMM) (drugs covered under health benefit)

Part 1 Cardholder/ Member Information

Cardholder ID No. _____

Cardholder Name _____ Address _____

City _____ State _____ Zip _____

Member Information - Use a separate claim form for each family member

Part 1 must be fully completed to ensure proper reimbursement of your claim.

Member Name _____ Date of Birth ____/____/____

Member: Male Female Relationship: Self Spouse Child Other _____

Are any of these medicines being taken for an on-the-job injury: Yes No

Is the medicine covered under any other group insurance? Yes No

Please type or print clearly.

If yes, is other coverage: Primary Secondary If other coverage is Primary, include the explanation of benefits (EOB) with this form.

Name of Insurer _____ Policy # _____ ID # _____ Phone () _____

I certify that I (or my eligible dependent) have received the medicine described herein and that the member named is eligible for prescription benefits. I also certify that the medicine received is not for treatment of any on-the-job injury or covered under another benefit plan. I authorize release of all information pertaining to this claim to Catalyst RX, the plan administrator, insurance underwriter, plan sponsor, policyholder and/or employer. I certify that all the information entered on this form is correct.

X _____ / ____ / ____

Signature of Cardholder or Legal Representative _____ Date _____

Part 2 Important! Please remember to include all original pharmacy receipts.

- Member Name
- Pharmacy Name and address or NABP Number
- Prescription Number
- Date Purchased
- Total Charge
- Medicine Strength/or NDC Number
- Medicine Name
- Metric Quantity, Days Supply

Part 3 Pharmacy Information

- To ensure that the member receives accurate and timely reimbursement for medical purchases, please assist in completing the information below.
- If compound prescription, please enter COMPOUND RX in the space designated for the NDC # and complete the Compound Prescriptions sections on the reverse side.

Pharmacist to complete this section ONLY if original pharmacy receipts are not included.

Pharmacy Name _____ Pharmacy NABP No. _____

Pharmacy Address _____ City _____

State _____ Zip _____ Phone () _____

I hereby certify that all the information listed below is correct and represents the actual charge(s) for prescription(s) dispensed. I further understand that all benefits payments as related to the charges listed below will be paid directly to the cardholder.

X _____ / ____ / ____

Signature of Pharmacist of Representative _____ Date _____

(Required only if original pharmacy receipts are not included)

| | | | | | |
|------|-------|----------------------------|----------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Rx 1 | Rx # | Date Filled (mm/dd/yy) | Prescriber's DEA No. | <input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound | For office use only Prior Approval Code |
| | NDC # | Medicine Name and Strength | Metric Quantity | Days Supply | Total Charges |
| Rx 2 | Rx # | Date Filled (mm/dd/yy) | Prescriber's DEA No. | <input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound | For office use only Prior Approval Code |
| | NDC # | Medicine Name and Strength | Metric Quantity | Days Supply | Total Charges |
| Rx 3 | Rx # | Date Filled (mm/dd/yy) | Prescriber's DEA No. | <input type="radio"/> New <input type="radio"/> Refill <input type="radio"/> DAW <input type="radio"/> Compound | For office use only Prior Approval Code |
| | NDC # | Medicine Name and Strength | Metric Quantity | Days Supply | Total Charges |

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any insurance company 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

HOW TO COMPLETE THIS FORM

Cardholder / Member Information

Complete all cardholder and member information in Part 1 on the reverse side.

- The Cardholder ID number can be found on your ID Card.
- Sign and Date in the space provided. Your signature certifies that the information is correct and complete.
- Please make a copy of all documents and receipts before you mail. No documents will be returned.

CLAIM SUBMISSION

To avoid delays in handling your claim, be sure all information is complete and correct.

A separate claim form must be completed for:

- Each member
- Each pharmacy from which you purchase

File as soon as possible after the date of service.

Your claim must be filed within 365 days from the service date.

DO NOT include charges for durable medical equipment that required a prescription to obtain. Please submit durable medical equipment on the Member Claim Form.

DO NOT submit cancelled checks, cash register slips or personal itemization. These are not acceptable as substitutes for original receipts.

DO NOT submit statements with "balance" amounts only.

PHARMACY INFORMATION

If a compound prescription, enter the NDC number of the most expensive ingredient of the legend medicine use.

| C O M P O U N D P R E S C R I P T I O N S | | | |
|-------------------------------------------|-------------------------|----------|--------|
| For pharmacy use only | | | |
| NDC # | Prescription Ingredient | Quantity | Charge |
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MAIL THIS FORM TO:

Catalyst RX
Claims Department
PO Box 1069
Rockville, MD 20849-1069