

Action Benefits

Fran Document Number: 6566

BCBSM Drug Claim Form with Instructions

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INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE DRUG CLAIM FORM

- Please print or type information clearly in the appropriate areas.
- Complete a separate claim form for each patient.
- Attach each patient's receipts to his/her claim form.
- Your pharmacist can assist you in providing information requested.
- **Mail the white copy to: Blue Cross and Blue Shield of Michigan (please note the address on the claim form).**
- Retain the yellow status inquiry copy. Instructions for submitting a status can be found on the back of the yellow claim form.

EXAMPLE OF A PROPERLY COMPLETED CLAIM FORM

Blue Cross Blue Shield of Michigan is an Independent Licensee of the Blue Cross and Blue Shield Association.

CONTRACT NUMBER: 123-456-789
 GROUP NO.: 12345
 ENROLLEE/SUBSCRIBER LAST NAME, FIRST: DOE J.
 PAYMENT TO SUBSCRIBER
 PHARMACY NAME: RX PHARMACY
 STREET ADDRESS: 100 MAIN
 CITY: HOMETOWN MI 48123
 DISPENSING INDICATOR (DI): X
 NATIONAL DRUG CODE: 0004510052160
 TOTAL CHARGE: 19.38
 PATIENT'S FIRST NAME: JOHN
 DATE OF BIRTH: 01/07/50
 PATIENT'S SEX: M
 RELATIONSHIP TO SUBSCRIBER: SELF
 OTHER INSURANCE: NO
 NAME: JOHN DOE
 DATE OF SERVICE: 01/07/50
 PRESCRIPTION NO.: 1234
 REFILL: 3
 QUANTITY: 30
 DAYS SUPPLY: 30
 NATIONAL DRUG CODE: 0004510052160
 CP: []
 TOTAL CHARGE: 19.38
 LINE 1 (NAME OF DRUG): TYLENOL #3
 LINE 2 (NAME OF DRUG):
 LINE 3 (NAME OF DRUG):
 NAME OF SUBSCRIBER: JOHN DOE
 STREET ADDRESS OF SUBSCRIBER: 123 OAK AVE.
 CITY: YOURTOWN MI 48124
 STATE: MI 48124
 ZIP CODE: 48124
 FOR BCBSM USE ONLY
 CERTIFICATION STATEMENT: I certify that the patient for whom this claim is made is eligible for the Blue Cross and Blue Shield of Michigan Drug Program, and that the prescription is for the sole use of that member. I hereby assume responsibility for any information pertaining to claims under the contract from medical or pharmaceutical records determined to be necessary by Blue Cross and Blue Shield.
 PHARMACIST'S CERTIFICATION STATEMENT: I certify the amount noted above as my charge for the described service which was performed by me.
 MAIL WHITE COPY OF CLAIM FORM TO: BLUE CROSS AND BLUE SHIELD OF MICHIGAN P.O. BOX 1600 DETROIT, MI 48231-0600

SEE BACK OF CLAIM FORM FOR DETAILED INSTRUCTIONS

INSTRUCTIONS FOR COMPLETING/SUBMITTING THE ATTACHED DRUG CLAIM FORM

Please print the following information clearly in the appropriate areas on the claim form. If you are submitting more than one claim, each form must be filled out completely. However, you may now submit up to three items per patient on one claim form as long as all three items are from the same pharmacy.

- CONTRACT NUMBER..... Your nine-digit contract number on your Blue Cross and Blue Shield of Michigan (BCBSM) I.D. card.
- GROUP NUMBER..... The group number or description found on your I.D. card.
- COVERAGE..... The service code or description found on your I.D. card.
- ENROLLEE/SUBSCRIBER LAST NAME, FIRST..... Your complete last name followed by first name.
- PROVIDER NAME, ADDRESS AND NABP NUMBER..... The name, address and NABP number of the pharmacy from which you purchased the drug.
- PATIENT'S NAME, BIRTHDATE, SEX AND RELATIONSHIP TO SUBSCRIBER..... Print patient's first name, birthdate, sex, and mark the appropriate box to identify patient's relationship to the subscriber.
- OTHER INSURANCE..... If patient has other insurance besides BCBSM, mark YES and name the company, if not, check NO.
- DATE OF SERVICE..... Enter the date that the prescription was purchased.
- PRESCRIPTION NO..... The prescription number as it appears on the prescription order.
- REFILL..... Enter the letter "O" of original prescription. Enter "1" if 1st refill. Enter "2" if 2nd refill, etc.
- QUANTITY..... The quantity of the drug (# tablets, cc, gm, etc.)
- DAYS SUPPLY..... The number of days supply for which the prescription is dispensed.
- DI (DISPENSING INDICATOR)..... If doctor indicates on prescription Dispense As Written (DAW), mark "X" in the box. If not, leave blank.
- NATIONAL DRUG CODE..... Eleven-digit code which identifies the drug dispensed.
- CP (COMPOUND INDICATOR)..... If drug is a compounded prescription, mark "X" in the box. If not, leave blank.
- TOTAL CHARGE..... The cost of the prescription, excluding tax.
- LINE 1, LINE 2, LINE 3..... The complete name of the drug, the strength, and the dosage form (tablet, capsule, etc.).
- SUBSCRIBER ADDRESS..... The complete address to which your payment should be mailed.
- RECIPIENT SIGNATURE..... Recipient of the prescription should sign in the space provided.
- PHARMACIST'S SIGNATURE..... Sign in the space provided.
- ATTACH COPY OF RECEIPT..... Staple copy of receipt to white copy of claim form.

