Medicaid Prescription Drug Claim Form

Blue Cross Community Health Plans℠

Member information (See other side for instructions)

ID number

Group number

Date of birth / / ❑ Male ❑ Female

Name (First, Last)

Street address

City State Zip

Member's relationship to primary cardholder:

❑ Self ❑ Spouse/Domestic partner ❑ Dependent/Child

I certify that:

- The information on this form is correct
- The member named above is eligible for pharmacy benefits
- The member named above received the medicine(s) listed
- I give my permission to share the information on this form with Prime Therapeutics LLC

X

Member or legal representative signature

Is this medicine for an on-the-job-injury? ❑ Yes ❑ No

Do you have other insurance for this prescription medicine? ❑ Yes ❑ No

If yes, what is the other insurance company's name?

Cardholder information (primary cardholder)

Name (First, Last)

Why are you submitting this Prescription Drug Claim Form? (check one)

☐ Did not have my pharmacy card with me when I bought this prescription

☐ Have not received my pharmacy card

☐ Picked up my medicine from a non-network pharmacy

☐ My other insurance is paying for part of this medicine (attach that company's Explanation of Benefits and an itemized receipt)

☐ Other (please explain)

Pharmacy information

Pharmacy name

Pharmacy address

City State Zip

X

Pharmacist signature

Prescription (Rx) claim information

Was this prescription medicine purchased outside the U.S.? . . . . . ❑ Yes ❑ No

All fields below must be completed. (See example on the back of this form.) Talk to your pharmacist if you need help.

Please attach original itemized pharmacy receipts. (A cash register receipt is not acceptable.)

1 Rx number

Date filled / /

Quantity Days' supply

Name of medicine

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Total prescription charge $.

2 Rx number

Date filled / /

Quantity Days' supply

Name of medicine

NDC number

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number

Total prescription charge $.

Instructions

1. Use a separate claim form for each member. All information provided on or attached to this claim form must be for the same person.
2. Attach original itemized pharmacy receipts provided with your prescription. Be sure that all the required information is visible (staple to the top of the form, if necessary). Note: your claim will be sent back if required information is missing.

Required information

- Member name
- ID number
- Group number
- Date of birth
- Pharmacy name and address
- Total charge
- Drug name and NDC number
- Physician NPI number
- Quantity
- Date filled
- Rx number
- Days' supply
- All compound drug information (if applicable)

Questions?

- You can call the number on the back of your member ID card
- Your pharmacist may call 800.821.4795

3. Keep a copy of this form and pharmacy receipts for your records. Send the original form and pharmacy receipts to:

Prime Therapeutics
Mail Route: Prime-GP Medicaid
PO Box 25137
Lehigh Valley PA 18002-5137

EXAMPLE

Rx number 0 0 0 0 0 6 0 1 1 4 8 1

Date filled 0 1 / 1 2 / 1 7

Quantity 30 Days' supply 3 0

Name of medicine "Drug Name"

NDC number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the national drug code (NDC) and national provider identifier (NPI) numbers.)

Physician NPI number 9 2 1 5 2 4 1 1 6 3

Total prescription charge $ 2 0 5 . 1 4

Is this prescription claim for a compound medicine?
❑ Yes ❑ No

Note: If yes, ask your pharmacist to complete the information below.

Compound Information

Please enter all information for each drug used.

Compound Prescriptions

For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

Rx 2

Attach original itemized pharmacy receipts here

All required information must be visible (see step 2 above).

Keep a copy of this form and your receipt(s) for your records.

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

To ask for supportive aids and services, or materials in other formats and languages for free, please call, 1-877-860-2837 TTY/TDD:711.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-860-2837 (TTY/TDD: 711**).

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-860-2837 (TTY/TDD: 711)**.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-860-2837 (TTY/TDD: 711)**.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-860-2837 (TTY/TDD: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-860-2837 (ATS : 711).**

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-860-2837 (TTY/TDD: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-860-2837 (TTY/TDD: 711)**.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-860-2837 (TTY/TDD: 711)**번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-860-2837 (телетайп: 711)**.

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-**778-068-7382** (رقم هاتف الصم والبكم: 117).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-860-2837 (TTY/TDD: 711)** पर कॉल करें।

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-860-2837 (TTY/TDD: 711)**.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711)**.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، آپ کو زبان کی مدد کی مفت خدمات دستیاب ہیں۔ کال کریں

1-877-860-2837 (TTY/TDD: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-860-2837 (TTY/TDD: 711)**.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-860-2837 (TTY/TDD: 711)**.