blue california

Medicare Part D: Prescription claim reimbursement form

Please check if applicable:

☐ This prescription was covered by a drug manufacturer patient assistance program.

Important!

- Your claim will be processed within 14 days of receipt. Please allow additional time for all associated mailings.
- Keep a copy of all documents submitted for your records.
- Do not staple or tape receipts or attachments to this form.

Step 1 **Patient information**

This section must be fully completed to ensure proper reimbursement of your claim.

Patient information

Identification number (refer to your prescription card)

Group number/group name

Last name

First name

MI

Address

Address 2

City

State

ZIP

Date of birth

☐ Male ☐ Female ☐ Nonbinary

Area code + phone number

Pharmacy information

Pharmacy name

Address

City

State

ZIP

Phone number

Is this an on-site nursing home pharmacy? ☐ Yes ☐ No

NCPDP/NPI required

Pharmacy service type

x _____

Signature of pharmacist or representative **(REQUIRED)**

Other insurance information

Please choose from below:

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

If yes, is other coverage: ☐ Primary ☐ Secondary

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

Name of insurance company _____

ID# _____

Type of request

Is this a request for a drug tier change? ☐ Yes ☐ No

Were any of these medicines received from a compounding facility? ☐ Yes ☐ No _____ Date

Were any of these medicines received from a hospital? ☐ Yes ☐ No

Were any of these medicines received from a long-term care facility? ☐ Yes ☐ No

Were any of these medicines received while on vacation? ☐ Yes ☐ No

Important! A signature is **REQUIRED**

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines, denial of benefits, and/or imprisonment.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I certify that I (or my eligible dependent) have received the medicine described herein. I certify that I have read and understood this form, and that all the information entered on this form is true and correct.

X _____

Signature of plan participant (**Required**)

Please note: If completing this form on behalf of a Medicare Part D member, please submit a completed CMS 1696 form (Appointment of Representative form). Per CMS regulations, a purported representative may submit a completed CMS 1696 form or a form that includes the same information as a 1696 form.

Step 2 Submission requirements:

You MUST include all original pharmacy-related receipts in order for your claim to process. The minimum information that must be included on your pharmacy receipts is listed below:

• Patient name • Prescription number • Drug's 11 digit NDC number • Date of fill • Quantity of drug • Total paid
• Days supply for your prescription (you need to ask your pharmacist for this "day supply" information)

Prescribing physician's name _____

Prescribing physician's address _____

Prescribing physician's phone number _____

Prescribing physician's national provider identifier (NPI) number _____

Additional comments _____

Dispensing unit for compounds _____

Number of prescriptions you are submitting for reimbursement consideration _____

Step 3 Mail completed forms with receipts to:

Claims Processing*
1606 Avenue Ponce de Leon
San Juan, PR 00909-4830

*Your claim will be processed by Abarca Health, contracted by Blue Shield of California for processing outpatient prescription drug claims.

IMPORTANT REMINDER - To avoid having to submit a paper claim form:

- Always have your member ID card available at time of purchase.
- Use medication from your plan's formulary list.
- Always use pharmacies within your plan's network.
- If problems are encountered at the pharmacy, call the Customer Service number on your member ID card.

Prescription claim information

Prescription 1	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply
Prescription 2	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply
Prescription 3	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply
Prescription 4	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply
Prescription 5	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply
Prescription 6	Drug name		
	Prescription (Rx) number	Date written (MM/DD/YYYY)	Date filled (MM/DD/YYYY)
	National drug code (NDC number)	Number of fills authorized	Fill number
	Total paid ($ amount)	Quantity of drug	Days supply