Prescription claim reimbursement form

Important

- If your claim is approved, you can expect a reimbursement check within four to six weeks from when we received your claim.
- Keep a copy of all documents submitted for your records.
- Do not staple receipts or attachments to this form.
- Reimbursement is not guaranteed, and your claims may be subject to limitations, exclusions, and provisions of the plan.

Step 1 Subscriber/dependent information

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

Cardholder information

Identification number (Refer to your ID prescription card)

Group number/group name

Last name

First name (MI)

Address

Address 2

City

State ZIP Country

Patient information – Use a separate claim form for each patient

Last name

First name (MI)

Date of birth Male Female Nonbinary Area code and phone number

Relationship to primary member

Member Spouse Child Other If other, please explain:

Pharmacy information

Pharmacy name

NCPDP/NPI required

Address

City State ZIP

Required: Please check appropriate box for submitting a paper claim. (Tape receipts and/or itemized bills on another sheet of paper.)

Reason(s) for submitting this form:

- ☐ Allergy/allergen clinic-related expense
- ☐ Pharmacy does not accept insurance
- ☐ Compound
- ☐ No insurance coverage at the time
- ☐ Other – provide reason below

☐ **Medication purchased outside of the United States** (Tape receipts and/or itemized bills on another sheet of paper)

Please indicate:

Country

Currency used:

Other insurance information

Coordination of benefits (COB)

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

If yes, other coverage is:

☐ Primary ☐ Secondary

Name of insurance company:

ID#:

Pharmacy information (Cont.)

Phone number

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

Pharmacy service type _____

x _____

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

Important: Signature is **REQUIRED**

NOTICE

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 patient **(REQUIRED)** Date

Step 2 Submission requirements

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

- Patient name
- Prescription number
- Medicine NDC number
- Date of fill
- Metric quantity
- Total charge
- Days supply for your prescription (you need to ask your pharmacist for this "day supply" information)
- Pharmacy name and address or pharmacy NCPDP number

Dispensing unit for compounds _____

Number of prescriptions you are submitting for reimbursement consideration _____

Prescribing physician's national provider identification (NPI) number (required) _____

Prescribing physician's information (all fields required)

Name _____

Address _____

City, state, ZIP code _____

Phone _____

Additional comments _____

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.
- 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.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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