



PLEASE PRINT										<b>SUBSCRIBER INFORMATION</b>													
SUBSCRIBER NAME (Last Name, First Name)					SUBSCRIBER I.D. NO.					GROUP NO.					PLAN CODE <b>110</b>								
PATIENT'S FIRST NAME			DOES PATIENT HAVE OTHER DRUG COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO			PATIENT'S GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			RELATIONSHIP OF PATIENT TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			PATIENT DATE OF BIRTH			MO			DAY			YEAR		
MAILING ADDRESS OF SUBSCRIBER (Number and Street)							PLEASE CHECK IF NEW ADDRESS <input type="checkbox"/>			CITY			STATE			ZIP CODE							
I CERTIFY THAT THE PATIENT FOR WHOM THIS CLAIM IS MADE IS A COVERED PERSON IN THIS PRESCRIPTION DRUG PROGRAM AND THAT THE PRESCRIPTION IS FOR THE SOLE USE OF THE NAMED PATIENT. I ALSO CERTIFY THAT THE CLAIM(S) BEING SUBMITTED ARE NOT ELIGIBLE FOR PAYMENT UNDER A NO-FAULT AUTOMOBILE OR WORKER'S COMPENSATION INSURANCE PROGRAM. (Enrollee/Authorized Representative) X _____ (Date) _____																							

<b>PRESCRIPTION INFORMATION</b>																							
CLAIM NUMBER <b>1</b>		FOR OFFICE USE ONLY		Rx NUMBER			DATE Rx FILLED			NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer. If Compounded Rx complete reverse side.)											
NATIONAL DRUG CODE						QUANTITY			DAY SUPPLY			NAME OF PRESCRIBING PHYSICIAN						PRESCRIPTION PRICE Including all discounts \$					
LABEL BRAND			PRODUCT NO.																				PKG/
DIAGNOSIS						N.A.B.P. PHARMACY NO.			NAME AND ADDRESS OF PHARMACY														
CLAIM NUMBER <b>2</b>		FOR OFFICE USE ONLY		Rx NUMBER			DATE Rx FILLED			NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer. If Compounded Rx complete reverse side.)											
NATIONAL DRUG CODE						QUANTITY			DAY SUPPLY			NAME OF PRESCRIBING PHYSICIAN						PRESCRIPTION PRICE Including all discounts \$					
LABEL BRAND			PRODUCT NO.																				PKG/
DIAGNOSIS						N.A.B.P. PHARMACY NO.			NAME AND ADDRESS OF PHARMACY														
CLAIM NUMBER <b>3</b>		FOR OFFICE USE ONLY		Rx NUMBER			DATE Rx FILLED			NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer. If Compounded Rx complete reverse side.)											
NATIONAL DRUG CODE						QUANTITY			DAY SUPPLY			NAME OF PRESCRIBING PHYSICIAN						PRESCRIPTION PRICE Including all discounts \$					
LABEL BRAND			PRODUCT NO.																				PKG/
DIAGNOSIS						N.A.B.P. PHARMACY NO.			NAME AND ADDRESS OF PHARMACY														
CLAIM NUMBER <b>4</b>		FOR OFFICE USE ONLY		Rx NUMBER			DATE Rx FILLED			NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer. If Compounded Rx complete reverse side.)											
NATIONAL DRUG CODE						QUANTITY			DAY SUPPLY			NAME OF PRESCRIBING PHYSICIAN						PRESCRIPTION PRICE Including all discounts \$					
LABEL BRAND			PRODUCT NO.																				PKG/
DIAGNOSIS						N.A.B.P. PHARMACY NO.			NAME AND ADDRESS OF PHARMACY														
CLAIM NUMBER <b>5</b>		FOR OFFICE USE ONLY		Rx NUMBER			DATE Rx FILLED			NEW <input type="checkbox"/>	REFILL <input type="checkbox"/>	NAME OF DRUG/STRENGTH/DOSAGE FORM (If generic include manufacturer. If Compounded Rx complete reverse side.)											
NATIONAL DRUG CODE						QUANTITY			DAY SUPPLY			NAME OF PRESCRIBING PHYSICIAN						PRESCRIPTION PRICE Including all discounts \$					
LABEL BRAND			PRODUCT NO.																				PKG/
DIAGNOSIS						N.A.B.P. PHARMACY NO.			NAME AND ADDRESS OF PHARMACY														

**PLEASE READ INSTRUCTIONS ON REVERSE SIDE**

# INSTRUCTIONS

## A. WHEN TO USE THIS FORM

This claim form is to be used to obtain reimbursement for a prescription drug that was not submitted on-line by your pharmacist because you did not present your identification card at the time the prescription was filled, or because the pharmacy which filled your prescription was a non-participating pharmacy.

Submit this form as soon as you have your prescription(s) filled in order to receive prompt payment. It IS NOT necessary to retain the form until you have filled in five prescription claims.

## B. HOW TO COMPLETE THIS FORM

1. Complete the upper portion of the claim form under SUBSCRIBER information. Transfer the **subscriber identification number** and **group number** from your identification card or enrollment application.
2. A separate claim form must be completed for each **patient**.
3. Complete the PRESCRIPTION information for each prescription. If you are unable to have the form from information supplied on the prescription label and/or receipt, ask your pharmacist to complete the form.
4. The **original paid** pharmacy receipt (including the required drug information) MUST accompany this form. Since pharmacy receipts cannot be returned, you may wish to make copies for your records. Personal itemizations, tax statements, cash register tapes, and cancelled checks are not acceptable receipts.

**IMPORTANT:** The drug quantity and EITHER the drug name an strength OR national Drug Code is required and **MUST** appear on the submitted claim(s) or receipt(s).

5. FOR COMPOUNDED PRESCRIPTIONS ONLY — If your pharmacist tells you this is a compounded prescription, you must complete the area below. Ask your pharmacist for assistance. Should you have more than two compounded prescriptions, please use additional forms.

CLAIM	COMPOUND INGREDIENTS		
#	DRUG NAME	QTY.	COST

CLAIM	COMPOUND INGREDIENTS		
#	DRUG NAME	QTY.	COST

**Medicare Part D Supplemental Benefit**—If your pharmacy cannot electronically submit prescription drug claims that are covered by policies that supplement Medicare Part D, please complete this reimbursement form. Attach your primary Medicare Part D prescription drug claim receipts and your primary Medicare Part D Explanation of Benefits that includes the prescription drug claim information for each of the claims you are submitting for supplemental processing. Please submit **all** secondary prescription drug claims for processing..

## C. WHERE TO MAIL THIS FORM

Mail this form and your original **paid** pharmacy receipt(s) to:

Blue Cross of Idaho/WellPoint NextRx  
 Prescription Drug Program  
 P.O. Box 9083  
 Oxnard, CA 93031-9083

### NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any factual material thereto, commits a fraudulent insurance act, which is a crime.