

COB



Blue Shield of California Prescription Drug Benefit* Direct Reimbursement Claim

blue shield of california

*Also applies to outpatient prescription drug benefits available through plans underwritten by Blue Shield of California Life & Health Insurance Company.

PART ONE: To Be Filled Out By You

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SUBSCRIBER IDENTIFICATION NUMBER

0	1	9	1	0	0	0	0
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CUSTOMER NUMBER

Do you have Medicare Part D coverage with Blue Shield of California? Yes No

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SUBSCRIBER NAME

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MAIL ADDRESS - STREET

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CITY STATE ZIP

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PATIENT'S NAME

	/		/	
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PATIENT'S DATE OF BIRTH (MM/DD/YY)

SEX: MALE FEMALE

RELATIONSHIP:

SUBSCRIBER SPOUSE CHILD
 OTHER: _____

EXPLAIN RELATIONSHIP

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DAYTIME TELEPHONE

The undersigned certifies that the medication(s) described herein was received by the undersigned for the party(s) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury or covered under another benefit plan. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan programs. Information may also be used for other reporting and analysis purposes without identification of the undersigned or the undersigned's family members. The undersigned further authorizes use of such person's subscriber identification number for identification purposes and further recognizes that reimbursement will be paid directly to the participant and assignment of these benefits to a pharmacy or otherwise is void.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

PART TWO: Pharmacy Information - To Be Filled Out By You or Your Pharmacist

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PHARMACY NAME

--

ADDRESS - STREET

--

PHARMACY ID (NCPDP/NPI)

--

CITY

STATE

ZIP

()

PHARMACY TELEPHONE

Rx 1

TAPE PHARMACY LABEL RECEIPT

Rx 2

TAPE PHARMACY LABEL RECEIPT

Rx 3

TAPE PHARMACY LABEL RECEIPT

Rx 4

TAPE PHARMACY LABEL RECEIPT

FOR COMPOUNDS

For Compounds: Pharmacist to identify the specific prescription by date of service and Rx number. Please list name, NDC# and metric quantities of each ingredient in box on left.

X

Signature of Pharmacist for Compounds

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INSTRUCTIONS

PLEASE WAIT UNTIL YOU RECEIVE YOUR BLUE SHIELD I.D. CARD BEFORE SENDING THIS CLAIM FOR REIMBURSEMENT. CLAIMS WITHOUT THE PROPER IDENTIFICATION NUMBER FROM YOUR BLUE SHIELD I.D. CARD WILL NOT BE PROCESSED.

To avoid undue delay, please complete all required areas of information on the claim form.

Please be sure to copy the last 9 letters and digits from your subscriber identification number (ID#) exactly as it appears on the Blue Shield identification card. If this is not done, the claim form will be returned to you. Please also ensure to keep a copy of your receipt(s) for your records.

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HOW TO COMPLETE THIS FORM

PART ONE

Subscriber Information

1. Copy the last 9 letters and digits from the Subscriber Identification Number on the Blue Shield I.D. Card.
2. Subscriber name, address, and telephone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.
7. Please use separate claim form for each family member.

PART TWO

Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy ID (NCPDP/NPI): Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape a copy of pharmacy label receipts to the form in the space provided. The receipts must indicate date of service, Rx number, NDC number, quantity, days supply and the amount paid.
4. Use a **separate claim form** for each pharmacy from which you purchase prescriptions.

Note: Claim submission is not a guarantee of payment.

Reason for Claim Submission:

- | | |
|--|---|
| <input type="checkbox"/> Member not eligible in system | <input type="checkbox"/> Out of Network Pharmacy Utilized |
| <input type="checkbox"/> Member in COBRA group | <input type="checkbox"/> Vacation Supply |
| <input type="checkbox"/> No Rx Card presented | <input type="checkbox"/> Compound |
| <input type="checkbox"/> Pharmacy online system down | <input checked="" type="checkbox"/> COB |

Submit to:

Blue Shield
Argus Health Systems, Inc.
PO BOX 419019, Dept. 191
Kansas City, MO 64141

Other Reason:

- Foreign Claims
- Other _____
- _____
- _____

Instructions:

Include your prescription receipt with the name of the drug(s), and state the foreign currency used.

Fill out this form, attach the prescription receipt.

Fill in boxes at bottom of form on the other side.

Submit to:

Blue Shield
c/o Pharmacy Services
PO BOX 7168
San Francisco, CA 94120-7168

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