



PLAN CODE

0 4 0

CERTIFICATE/SUBSCRIBER ID NUMBER

Grid for Certificate/Subscriber ID Number

(THIS NUMBER IS ON YOUR ID CARD)

PRESCRIPTION DRUG CLAIM FORM

INSURED: PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE.

Insured Name (PLEASE PRINT), Insured, Mailing Address, First, Middle, Last, Street, City, State, Zip Code

PRESCRIPTIONS WERE DISPENSED TO: (Use a separate claim form for each individual patient.)

PATIENT NAME (PLEASE PRINT), PATIENT BIRTHDATE, SEX, RELATIONSHIP TO INSURED (CHECK ONE BOX)

NOTE: USE A SEPARATE CLAIM FORM FOR EACH PATIENT. DO NOT SEND IN COMPUTER PRINTED RECEIPTS OR PHOTOCOPIES OF THE COMPLETED CLAIM FORM.

DOES THAT PATIENT HAVE OTHER HEALTH INSURANCE COVERAGE? YES NO IF YES, YOU MUST COMPLETE THE FOLLOWING:

DOES THE OTHER COVERAGE INCLUDE: MAJOR MEDICAL DRUG OTHER MEDICAL

INSURED'S NAME, SPOUSE'S BIRTHDATE, INSURED'S ID NUMBER, EFFECTIVE DATE, INSURANCE COMPANY NAME, ADDRESS

HAVE YOU BEEN TREATED WITHIN THE PAST 24 MONTHS FOR THE SAME CONDITION FOR WHICH ANY OF THESE DRUGS HAVE BEEN PRESCRIBED? YES NO

IF YES, INDICATE DATE FIRST TREATED IF YES, INDICATE THE CONDITION BEING TREATED

I certify that the above information is correct and that I have received the drugs described below. I also certify that the patient for whom this claim is made is eligible for benefits.

I authorize the pharmacy to furnish the administrator with any information it requests relating to the prescription(s) listed below.

THIS FORM MUST BE SIGNED: SIGNATURE Date

YOUR PHARMACIST MUST COMPLETE THIS SECTION: WE CANNOT PROCESS THIS FORM WITHOUT THIS INFORMATION.

Pharmacist: When using a Pharmacy computer or Point of Service device, you need to record only THE SHADED AREAS OF THE CLAIM FORM

SECTION "A"

Table with 4 rows for prescriptions, columns for RX NUMBER, DATE FILLED, CHECK ONE, METRIC QUANTITY, DAYS SUPPLY, PRESCRIBING PHYSICIAN, IS Rx, RX PRICE, REFERENCE NUMBER, MEDICATION NAME, IS DRUG, NDC NUMBER.

PHARMACIST MUST COMPLETE:

Pharmacy Name, Street Address, City, State, Zip code, PHARMACY NABP NUMBER, Total number of Prescriptions, TOTAL PRICE, THIS FORM MUST BE SIGNED BY PHARMACIST, Date

PATIENT MUST COMPLETE THIS SECTION

PHARMACIST REVIEW REVERSE SIDE FOR INSTRUCTIONS

## INSTRUCTIONS

Please read this carefully before completing the claim form.

**Claim forms without the required information cannot be processed.**

**Incomplete claim forms will be returned to you.**

## SUBSCRIBER:

- a. Bring this claim form **to the pharmacy** when you obtain prescription drugs.
- b. Use a **separate** claim form for each family member.
- c. You must complete the top portion of the claim form (certificate/subscriber ID number, name, address, etc.) before presenting it to the pharmacist.
- d. Give the claim form **to your pharmacist** to complete the lower portion (Rx number, drug dispensed, etc.)
- e. A cash register tape is **not** considered satisfactory evidence of purchase.
- f. A computer printout of the prescriptions from the pharmacy cannot be processed. The claim form must be completed on the reverse side. Your pharmacist may complete a Prescription Drug Universal Claim Form (UCF) and attach it to this form instead of completing the lower portion of this claim form.
- g. Mail the claim form directly to the address below:

**REMEMBER: The certificate/subscriber ID number and patient information must be valid and correct. The pharmacist must complete the lower portion of the claim form.**

**IF YOU HAVE QUESTIONS CALL:**

**1 (800) 678-DRUG**

## PHARMACIST:

When using a pharmacy computer or Point-of-Service (P.O.S.) device: YOU NEED TO RECORD ONLY THE REFERENCE NUMBER, PHARMACY NAME AND ADDRESS, NABP NUMBER AND YOUR SIGNATURE ONTO THE CLAIM FORM.

If you are not using a pharmacy computer or P.O.S. device:

- a. You should complete the lower portion in detail (Rx number, drug dispensed, etc.).
- b. You must provide the complete name and address of the pharmacy, NABP number, and authorized signature. The first six digits of your seven digit NABP number is the same as the provider number used for many other pharmaceutical administrators. If you have questions regarding your NABP number, please call the toll-free number listed below for instructions.
- c. You may complete a Universal Claim Form (UCF) instead of completing the lower portion of this claim form. **THE UCF MUST BE ATTACHED TO THIS CLAIM FORM AND MUST BE SUBMITTED BY THE SUBSCRIBER.** The pharmacy NABP number must be written on the front of the claim form or on the Universal Claim Form. Do not attach more than 4 prescriptions per Prescription Drug Claim Form.  
Do not include both reference number and non-reference number items on the same claim form. Claims that could not be placed on the Point-of-Service system should be entered on a separate Prescription Drug Claim Form.
- d. The DAW field indicates a situation where a generic drug could have been dispensed. If the physician requires that the brand drug be dispensed, the box marked MD DAW should be checked. The other boxes should be checked accordingly if the employee or pharmacist requests a brand name drug or if there is no generic drug available at the pharmacy.

**TO THE PHARMACIST - IF YOU HAVE QUESTIONS CALL: 1-800-678-DRUG**

Blue Cross of California prescription drug benefits are administered by WellPoint Pharmacy Management.

## MAIL TO:

WellPoint Pharmacy Management  
Attn: BLUE CROSS OF CALIFORNIA  
P.O. Box 4165  
Woodland Hills, CA 91365-4165