



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Instructions for Completing the Prescription Drug Program Subscriber Claim Form

Please note: One pharmacy and one subscriber per claim form

- I. **Subscriber and Patient Information:** This section must be filled out in its entirety for claims to be processed. The ID Number can be found on the subscriber's Blue Cross and Blue Shield of Florida ID card.
- II. **Patient Information:** This section must also be filled out in its entirety for claims to be processed.
- III. **Pharmacy Information:** The Pharmacy NABP number is a unique ID number assigned to each pharmacy and is required for claims processing. If this number is not found on the subscriber's receipt, it may be obtained from the pharmacy.
- IV. **Prescription Information:** Prescription Receipts are required for claims processing. Cash register receipts are not acceptable. Balance due field should be filled in when other insurance has paid as primary and a balance due is being requested.
- V. **Subscriber Certification:** The subscriber must sign the Subscriber Certification for claims to be processed.

Mail completed claim form and receipts to:

Prime Therapeutics LLC
Mail Route – BCBSFL
P.O. BOX 14430
Lexington, KY 40512-4430



PRESCRIPTION DRUG PROGRAM SUBSCRIBER CLAIM FORM

SEND COMPLETED FORM & PHARMACY RECEIPTS TO:

PRIME THERAPEUTICS LLC
Mail Route - BCBSFL
P.O. BOX 14430
Lexington, KY 40512-4430

Instructions

(see back of form for detailed instructions)

- 1. Sections I through IV - Complete sections in their entirety.
2. Section V - Be sure to sign.

I. SUBSCRIBER INFORMATION (MUST BE COMPLETED)
SUBSCRIBER NAME LAST FIRST M.I. DATE OF BIRTH
SUBSCRIBER ADDRESS STREET CITY STATE ZIP
SUBSCRIBER ID # H GROUP #

II. PATIENT INFORMATION (MUST BE COMPLETED)
PATIENT NAME LAST FIRST M.I. DATE OF BIRTH MO DAY YEAR SEX M F RELATIONSHIP TO SUBSCRIBER (Check One) SELF SPOUSE CHILD OTHER
Was condition related to an accident?
If yes, was it related to:
Is other insurance applicable to charge?
If yes, complete the information below, and attach explanation of benefits.
Other Carrier Name Policy #
Name of Subscriber

III. PHARMACY INFORMATION
PHARMACY NAME PHONE ()
STREET CITY, STATE, ZIP
PHARMACY NABP # Prescription Receipts Required for Processing

IV. PRESCRIPTION INFORMATION table with columns: DATE RX FILLED (MO, DAY, YR), RX NUMBER, QUANTITY, DAYS SUPPLY, NATIONAL DRUG CODE (NDC), DRUG NAME, PRESCRIPTION COST, BALANCE DUE

V. SUBSCRIBER CERTIFICATION
I Certify all information provided on this form and on the attached itemized statement to be true and correct to the best of my knowledge:
SUBSCRIBER SIGNATURE DATE / /

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.