

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THE DRUG CLAIM FORM

- Please print or type information clearly in the appropriate areas.
- Complete a separate claim form for each patient.
- Attach each patient's receipts to his/her claim form.
- Your pharmacist can assist you in providing information requested.
- **Mail the white copy to: Blue Cross and Blue Shield of Michigan (please note the address on the claim form).**
- Retain the yellow status inquiry copy. Instructions for submitting a status can be found on the back of the yellow claim form.

EXAMPLE OF A PROPERLY COMPLETED CLAIM FORM

INSTRUCTIONS FOR COMPLETING/SUBMITTING THE ATTACHED DRUG CLAIM FORM

Please print the following information clearly in the appropriate areas on the claim form. If you are submitting more than one claim, each form must be filled out completely. However, you may now submit up to three items per patient on one claim form as long as all three items are from the same pharmacy.

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| <p>CONTRACT NUMBER.....</p> <p>GROUP NUMBER.....</p> <p>COVERAGE.....</p> <p>ENROLLEE/SUBSCRIBER LAST NAME, FIRST.....</p> <p>PROVIDER NAME, ADDRESS AND NABP NUMBER.....</p> <p>PATIENT'S NAME, BIRTHDATE, SEX AND
RELATIONSHIP TO SUBSCRIBER.....</p> <p>OTHER INSURANCE.....</p> <p>DATE OF SERVICE.....</p> <p>PRESCRIPTION NO.....</p> <p>REFILL.....</p> <p>QUANTITY.....</p> <p>DAYS SUPPLY.....</p> <p>DI (DISPENSING INDICATOR).....</p> <p>NATIONAL DRUG CODE.....</p> <p>CP (COMPOUND INDICATOR).....</p> <p>TOTAL CHARGE.....</p> <p>LINE 1, LINE 2, LINE 3.....</p> <p>SUBSCRIBER ADDRESS.....</p> <p>RECIPIENT SIGNATURE.....</p> <p>PHARMACIST'S SIGNATURE.....</p> <p>ATTACH COPY OF RECEIPT.....</p> | <p>Your nine-digit contract number on your Blue Cross and Blue Shield of Michigan (BCBSM) I.D. card.</p> <p>The group number or description found on your I.D. card.</p> <p>The service code or description found on your I.D. card.</p> <p>Your complete last name followed by first name.</p> <p>The name, address and NABP number of the pharmacy from which you purchased the drug.</p> <p>Print patient's first name, birthdate, sex, and mark the appropriate box to identify patient's relationship to the subscriber.</p> <p>If patient has other insurance besides BCBSM, mark YES and name the company, if not, check NO.</p> <p>Enter the date that the prescription was purchased.</p> <p>The prescription number as it appears on the prescription order.</p> <p>Enter the letter "O" of original prescription. Enter "1" if 1st refill. Enter "2" if 2nd refill, etc.</p> <p>The quantity of the drug (# tablets, cc, gm, etc.)</p> <p>The number of days supply for which the prescription is dispensed.</p> <p>If doctor indicates on prescription Dispense As Written (DAW), mark "X" in the box. If not, leave blank.</p> <p>Eleven-digit code which identifies the drug dispensed.</p> <p>If drug is a compounded prescription, mark "X" in the box. If not, leave blank.</p> <p>The cost of the prescription, excluding tax.</p> <p>The complete name of the drug, the strength, and the dosage form (tablet, capsule, etc.)</p> <p>The complete address to which your payment should be mailed.</p> <p>Recipient of the prescription should sign in the space provided.</p> <p>Sign in the space provided.</p> <p>Staple copy of receipt to white copy of claim form.</p> |
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Blue Cross Blue Shield of Michigan is an independent licensee of the Blue Cross and Blue Shield Association.

CONTRACT NUMBER	
GROUP NO.	COVERAGE SERVICE CODE
ENROLLEE/SUBSCRIBER LAST NAME	FIRST

**PAYMENT
TO
SUBSCRIBER**



PHARMACY NAME		
STREET ADDRESS		
CITY	STATE	ZIP CODE
PROVIDER NO./NABP		

COMPLETE ALL ITEMS ON FORM • CONTACT PHARMACY FOR INFORMATION IN SCREENED AREAS

PATIENT'S FIRST NAME		DATE OF BIRTH MO DAY YEAR		PATIENT'S SEX M F		RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEP			OTHER INSURANCE YES NO		NAME	
LINE NO.	DATE OF SERV MO DAY YR	PRESCRIPTION NO.	REFILL	QUANTITY	DAYS SUPPLY	DI	NATIONAL DRUG CODE			CP	TOTAL CHARGE	
1							-----/-----/-----					
2							-----/-----/-----					
3							-----/-----/-----					
LINE 1 (NAME OF DRUG)				LINE 2 (NAME OF DRUG)				LINE 3 (NAME OF DRUG)				

PAYMENT FOR THE ABOVE PRESCRIPTION SERVICE WILL BE PAID TO THE SUBSCRIBER AND SENT TO THE ADDRESS GIVEN BELOW.

PLEASE PRINT

NAME OF SUBSCRIBER

STREET ADDRESS OF SUBSCRIBER

CITY STATE ZIP CODE

FOR BCBSM USE ONLY

CERTIFICATION STATEMENT

I certify that the patient for whom this claim is made is an eligible member of the Michigan Drug Program, and that the prescription is for the self. I have provided any information pertaining to claims under this contract from medical or pharmacy records as requested to be necessary by Blue Cross and Blue Shield.

X _____
RECIPIENT SIGNATURE

PHARMACIST'S CERTIFICATION STATEMENT

I certify the amount noted above is my charge for the described service which was performed by me.

X _____
PHARMACIST'S SIGNATURE

MAIL WHITE COPY OF CLAIM FORM TO: **BLUE CROSS AND BLUE SHIELD OF MICHIGAN**
P.O. BOX 500
DETROIT, MI. 48231-0500

ORIGINAL COPY

CLAIMS PAYMENT INQUIRY

Please check all information on reverse side for accuracy. Your original service report may have contained inaccurate information which has caused a delay. Allow a minimum of 45 days from submission of original Claim For Payment before sending this follow-up, unless a payment or rejection notice was received.

- If you are questioning a partial payment or rejection, please check the box "Rejection or partial payment received for this claim" and mail this copy to us with a copy of the check voucher or the Non-Payment notice we sent you. Our response will be sent to you as soon as possible.

REASON FOR SUBMISSION
(Complete Front of Form - Status Inquiry Only Section)

Other Reasons:

BLUE CROSS BLUE SHIELD USE ONLY
STATUS INQUIRY RESPONSE

- PAYMENT WAS MADE ON CHECK # _____ DATED _____.
- THE MAXIMUM BENEFIT HAS BEEN PAID FOR THIS SERVICE.
- THIS SERVICE IS NOT A BENEFIT UNDER THE PRESCRIPTION DRUG PROGRAM.

PLEASE CONTACT YOUR LOCAL BCBSM CUSTOMER SERVICE OFFICE FOR FURTHER BENEFIT INFORMATION AND INQUIRES. REQUEST FOR ADDITIONAL CLAIM FORMS SHOULD BE SENT TO:

BLUE CROSS BLUE SHIELD OF MICHIGAN
ATTN: DEPT. L800
53200 GRAND RIVER
NEW HUDSON, MICHIGAN 48165-9801