blue of california

Blue Shield of California Prescription Drug Benefit*

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

ARGUS A DST Company

PART ONE: To Be Filled Out By You

STOP

If you are a Medicare Part D subscriber, do **not** complete this form. Instead, visit our website (https://blueshieldca.com/bsc/medicarepartdplans/documentlibrary) to download a *Coverage Determination Form* ***OR*** contact your member service number, which is located on your ID card.

SUBSCRIBER IDENTIFICATION NUMBER

CUSTOMER NUMBER: 0 1 9 1 0 0 0 0

SUBSCRIBER NAME

MAIL ADDRESS – STREET

CITY STATE ZIP

PATIENT'S NAME

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

SEX: ☐ MALE ☐ FEMALE

RELATIONSHIP:

☐ SUBSCRIBER ☐ SPOUSE ☐ CHILD

☐ OTHER:_____

EXPLAIN RELATIONSHIP

( ) 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

PHARMACY NAME ADDRESS – STREET PHARMACY ID (NCPDP/NPI)

CITY STATE ZIP ( ) PHARMACY TELEPHONE

Medication # 1	Medication # 2
TAPE PHARMACY LABEL RECEIPT	TAPE PHARMACY LABEL RECEIPT
Medication # 3	**Medication # 4**
TAPE PHARMACY LABEL RECEIPT	TAPE PHARMACY LABEL RECEIPT

Medications compounded by Pharmacy

Compounded Medications: Pharmacist is to identify the specific medications by date of service and **Rx** number. Please list name, NDC# and metric quantities of each ingredient in the box at left.

X

Signature of Pharmacist for Compounded Medications

An Independent Member of the Blue Shield Association

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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 delays, complete all required areas of information on the claim form.

Be sure to copy the last nine 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.

Keep a copy of your receipt(s) for your records.

HOW TO COMPLETE THIS FORM

PART ONE

Subscriber Information

Medicare Part D subscribers, do **not** use this form!

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 for whom the drug was prescribed.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female.
6. Status: Patient's relationship to subscriber. If "other" is selected, please write in the type of relationship.
7. Please use a 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 this 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. For foreign claims, state the currency used.
4. For medications compounded by the pharmacy, the pharmacist must complete and sign the sections titled, "**Medications compounded by Pharmacy**" and "**Compounded Medications**" on page one of this form.
5. Use a **separate claim form** for the different pharmacies from which you have purchased prescriptions.

Note: Claim submission is not a guarantee of payment.

Reason for Claim Submission:	**Submit to:**
☐ Your Blue Shield membership was loaded late. ☐ Your Blue Shield ID Card was missing when you purchased your medication. ☐ Prior Authorization was approved after you purchased your medication. ☐ You did not use a pharmacy in the Blue Shield Pharmacy Network. ☐ The pharmacy was unable to process your prescription online due to system unavailability. ☐ Your medication was compounded especially for you by your pharmacy.	**Blue Shield of California** **Argus Health Systems, Inc.** **P.O. Box 419019,** **Dept 191** **Kansas City, MO 64141**
FOREIGN CLAIMS: Include your prescription receipt with the name of the drug(s) and state the foreign currency used.	**Submit to:** **Blue Shield of California** **Attn: Foreign Claims** **PO BOX 272550** **Chico, CA 95927-2550**
OTHER REASON: ☐ You obtained more medications than your plan covers because you required a vacation supply. ☐ Other reason: _____ _____	**Submit to:** **Blue Shield of California** **c/o Pharmacy Services** **PO BOX 7168** **San Francisco, CA 94120-7168**