HIGHMARK® BLUE SHIELD

An Independent Licensee of the Blue Cross and Blue Shield Association

MEMBER PRESCRIPTION DRUG CLAIM FORM

FILING INSTRUCTIONS

Please complete this form as instructed below to request reimbursement consideration.
Please review your contract to determine if the prescription drug is eligible for reimbursement.

PLEASE NOTE: You are required to pay the entire cost of any prescription drug at point of sale prior to requesting reimbursement.

PRE-EXISTING LIMITATION: If the drug is prescribed for a medical condition that was diagnosed or treated within the five (5) years immediately before your effective date of coverage, the prescribed drug is not eligible for reimbursement.

1. Complete **all** items below **including** your signature and date. **All** of the information is essential for prompt and accurate processing of your claim(s). Please do not highlight information or use red ink.
2. Please complete the Member Prescription Drug Claim Form and Part A of the Prescribing Physician Prescription Drug Form. Part B of the Prescribing Physician Prescription Drug Form must be completed by the physician.
3. **You must attach an itemized receipt from your pharmacy to this Form.** The itemized receipt must include:
   - Prescribing Provider's name
   - Patient's full name (no nickname, please)
   - Prescription drug name and number

   NOTE: Cancelled checks, cash register receipts or personal itemizations are not acceptable as itemized receipts.
4. You must use a separate claim form for each prescription drug. Do not submit more than one prescription drug on a form.
5. Mail completed claim form with all attached itemized receipts to:
   HIGHMARK, P.O. Box 890062, Camp Hill, PA, 17089-0062 or fax to 1-866-731-4589.

NOTE: PLEASE KEEP A COPY OF YOUR COMPLETED CLAIM FORM AND ITEMIZED RECEIPTS FOR YOUR RECORDS.

Patient Information

PATIENT'S NAME (first name, middle initial, last name)

PATIENT'S ADDRESS

Street

City State Zip Code

PATIENT'S DATE OF BIRTH (month, day, year)

PATIENT'S SEX ❑ MALE ❑ FEMALE

PATIENT'S RELATIONSHIP TO THE SUBSCRIBER NAMED ON ID CARD

❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

ID Card Information

SUBSCRIBER'S NAME ON ID CARD (first name, middle initial, last name)

IDENTIFICATION NUMBER ON ID CARD (including any letters)

GROUP NUMBER ON ID CARD

*EFFECTIVE DATE OF COVERAGE | COVERAGE END DATE

ADDRESS OF PERSON LISTED ON ID CARD

Street

City State Zip Code

*The Effective Date of Coverage is on the Member ID Card.

Certification

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The signer agrees that any personally identifiable health information about the signer or signer's enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 and other privacy laws. In accordance with those laws, Highmark may use and disclose Protected Health Information for treatment, payment and health care operations as described in its Notice of Privacy Practices. I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient name.

Signature _____ Date _____

PRESCRIBING PHYSICIAN PRESCRIPTION DRUG FORM

Please print with ink or type

Part A - Member Information

1. Patient's Name: _____

2. Patient's Effective Date of Coverage: _____

Part B - Prescribing Physician Information

Prescription Drug/Condition Information:

1. Drug Name: _____

2. Diagnosis (5 digit number): _____

3. Date the condition was originally diagnosed: _____

4. To the best of my knowledge, I was the physician who originally diagnosed the condition for which this drug was prescribed.
   ❑ Yes ❑ No

5. If you answered NO to Question #4, please provide the name of the physician who originally diagnosed or treated this patient for the condition for which this drug was prescribed during the five (5) years prior to the patient's Effective Date of Coverage.

   _____

Current Prescribing Physician Contact Information:

Physician Name *(first, middle initial, last)*

_____

Physician Telephone Number

( ) _____

Physician's Address

_____

Street Suite/Bldg City State Zip Code

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Signature _____ Date _____