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. This 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

Blue Cross of California

WELLPOINT
PHARMACY MANAGEMENT
For the Blue Cross of California
Prescription Drug Program
P.O. Box 4165, Woodland Hills, CA 91365-4165

PLAN CODE

0	4	0

CERTIFICATE/ SUBSCRIBER ID NUMBER ________ — ___

(THIS NUMBER IS ON YOUR BLUE CROSS ID CARD)

PRESCRIPTION DRUG CLAIM FORM

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

SUBSCRIBER MUST COMPLETE THIS SECTION

Subscriber Name *(PLEASE PRINT)* ______ First ______ Middle ______ Last

Subscriber Mailing Address ______ Street ______ City ______ State ______ Zip Code

PRESCRIPTIONS WERE DISPENSED TO: *(Use a separate claim form for each member)*

PATIENT NAME *(PLEASE PRINT)* ______ First ______ Middle ______ Last

PATIENT BIRTHDATE ___/___/___ M D Y SEX ☐ M ☐ F

RELATIONSHIP TO SUBSCRIBER (CHECK ONE BOX) ☐ SELF ☐ SPOUSE ☐ CHILD

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

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

DOES THE OTHER COVERAGE INCLUDE: ☐ MAJOR MEDICAL ☐ DRUG ☐ OTHER MEDICAL

SUBSCRIBER NAME ______ Last ______ First ______ Middle

SPOUSE'S BIRTHDATE ___/___/___ M D Y SUBSCRIBER ID NUMBER ______ EFFECTIVE DATE ______

INSURANCE COMPANY NAME ______

ADDRESS ______ Street ______ City ______ State ______ Zip Code

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 ___/___/___ M D Y 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. The drugs listed below are not for treatment of an occupational injury or disease, for which the Employer has accepted liability. The medication is not covered under any other group insurance plan or other employer.

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** ______

Patient/or Parent if a Minor

PHARMACIST REVIEW REVERSE SIDE FOR INSTRUCTIONS

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"

#	RX NUMBER	DATE FILLED	CHECK ONE	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBING PHYSICIAN DEA NUMBER OR NAME	IS RX:	RX PRICE
1.		M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO DAW ☐ 0 MD DAW ☐ 1 PATIENT DAW ☐ 2 RPh DAW ☐ 3 NO GENERIC ☐ 4 BRAND DISPENSED AS GENERIC ☐ 5	$
	REFERENCE NUMBER		MEDICATION NAME, STRENGTH, DOSAGE FORM (Optional)	IS DRUG: COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2		NDC NUMBER		
2.		M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO DAW ☐ 0 MD DAW ☐ 1 PATIENT DAW ☐ 2 RPh DAW ☐ 3 NO GENERIC ☐ 4 BRAND DISPENSED AS GENERIC ☐ 5	$
	REFERENCE NUMBER		MEDICATION NAME, STRENGTH, DOSAGE FORM (Optional)	IS DRUG: COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2		NDC NUMBER		
3.		M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO DAW ☐ 0 MD DAW ☐ 1 PATIENT DAW ☐ 2 RPh DAW ☐ 3 NO GENERIC ☐ 4 BRAND DISPENSED AS GENERIC ☐ 5	$
	REFERENCE NUMBER		MEDICATION NAME, STRENGTH, DOSAGE FORM (Optional)	IS DRUG: COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2		NDC NUMBER		
4.		M / D / Y	NEW RX ☐ 0 REFILL RX ☐ 1				NO DAW ☐ 0 MD DAW ☐ 1 PATIENT DAW ☐ 2 RPh DAW ☐ 3 NO GENERIC ☐ 4 BRAND DISPENSED AS GENERIC ☐ 5	$
	REFERENCE NUMBER		MEDICATION NAME, STRENGTH, DOSAGE FORM (Optional)	IS DRUG: COMPOUND RX ☐ 1 ALLERGY INJ. ☐ 2		NDC NUMBER		

PHARMACIST MUST COMPLETE:

______ Pharmacy Name

______ Street Address

City ______ State ______ Zip Code ______

______ Phone #

PHARMACY NABP NUMBER
SEE REVERSE SIDE FOR NABP NUMBER INSTRUCTIONS
IF DISPENSED BY PHYSICIAN USE ALL 9 SPACES FOR TIN NUMBER

Total number of Prescriptions: ______

TOTAL PRICE $

THIS FORM MUST BE SIGNED BY PHARMACIST: ______ Date ______
Pharmacist

NOTE: Payment for the above claim(s) will be made directly to the subscriber. Any assignment of these benefits must include the signature of the subscriber and is subject to approval.