

For Compounds

Pharmacist:

Identify the specific prescription by date of service and Rx number. List name, NDC# and metric quantities of each ingredient in box at right.

X

Signature of Pharmacist for Compounds

How to complete this form

Please print all information except signatures.

PART ONE

Subscriber Information

1. Copy the Subscriber (Member) ID from the ID Card.
2. Subscriber name, address and telephone number.
3. Patient Name: Person drug was prescribed for.
4. Patient Date of Birth: Month, Day, Year.
5. Patient Sex: Check Male or Female
6. Status: Patient's relationship to subscriber. If other, please write in type of relationship.

Please use separate claim form for each family member.

PART TWO

Coordination of Benefits (COB)

1. a. If you **do not** have Coordination of Benefits (COB) coverage (you are not covered by other health insurance), Check No. If you **do** have COB coverage (you are covered by other health insurance), check Yes and complete Part Two
b. If your claim has been processed by the other carrier, attach a **copy** of: Explanation of Benefits (EOB) or statement from other coverage and/or pharmacy receipt.
2. Name of insured policyholder.
3. Name of insured individual's employer.
4. Name of other insurance company.
5. Insurance policy number from other insurance company.

PART THREE

Pharmacy Information

1. Pharmacy name, address, and telephone number where the prescription(s) were purchased.
2. Pharmacy NABP Number: Obtain the number from the pharmacy where prescriptions were purchased.
3. Tape pharmacy 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.
4. Use a **separate claim form** for each pharmacy from which you purchase prescriptions.

MAIL THIS FORM TO:

Medi-CareFirst BlueCross BlueShield
Medicare Prescription Drug Plan Claims Center
c/o Argus Health Systems
P.O. Box 419019
Kansas City, MO 64141

Note: Claim submission is not a guarantee of payment.

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