Direct Claim Form

Instructions
Read carefully before completing this form.

1. To find out whether you qualify for a direct claim, review the requirements on the right.
2. The plan member should read the acknowledgment carefully, then sign and date this form.
3. Be sure your receipts are complete. All receipts must contain the information listed under "Claim receipts" on the back of this page. Please keep copies of your receipts.
4. Return the completed form and receipt(s) to:

BCBSNC Medicare Part D
Attn: Prescription Drug Claim
PO Box 17168
Winston-Salem, NC 27116

Complete all information on the claim form. An incomplete form may delay reimbursement.

BlueCross BlueShield of North Carolina

Does this claim qualify for coverage?

You may submit a claim for Part D-covered medication dispensed by a nonparticipating pharmacy **only in an emergency**. Check the box that applies to your emergency situation:

- ☐ A. I traveled outside my plan's service area and ran out (or lost) my medication / I became ill and could not access a network pharmacy.
- ☐ B. I was unable to obtain my medication in a timely manner within my service area (there was no network pharmacy within a reasonable driving distance that provides 24/7 service).
- ☐ C. My medication is not stocked regularly at an accessible network or mail-order pharmacy.
- ☐ D. My medication was dispensed from an emergency department, provider-based clinic, outpatient surgery facility, LTC, or other outpatient setting.
- ☐ E. I received a vaccine at my doctor's office.

Claim Receipts

Tape receipts or itemized bills on the back. **Do not staple!** Tape additional receipts on a separate piece of paper.

Check the appropriate box if any receipts or bills are for a:

- ☐ **Compound prescription** Your pharmacist must list a **valid** 11-digit NDC number for **each ingredient,** plus quantities, on the receipt or bill.

Member/Subscriber Information See your prescription drug ID card.

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City State Zip

Pharmacy Information

Name of Pharmacy

Street Address

City State Zip

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐**Yes** ☐**No**

I hereby certify that the charge(s) shown for the medication(s) prescribed is correct and agree to provide BCBSNC or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the plan member and assignment of these benefits to a pharmacy or any other party is void.

Signature of Pharmacist or Representative **(Required)**

NABP Number Required

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete, or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.*

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I am eligible for prescription drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X

Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!** If you have additional receipts, tape them on a separate piece of paper.

Tape receipt for prescription 1 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid
- Your pharmacist can provide the necessary information if your claim or bill is not itemized

Tape receipt for prescription 2 here.

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid
- Your pharmacist can provide the necessary information if your claim or bill is not itemized

PHARMACY INFORMATION (For Compound Prescriptions ONLY)

- List the VALID 11-digit NDC number for EACH ingredient used for the compound prescription.
- For each NDC number, indicate the "metric quantity" expressed in the number of tablets, grams, milliliters, creams, ointments, injectables, etc.
- Indicate the TOTAL charge (dollar amount) paid by the patient.
- Receipt(s) must be attached to claim form.

RX #		Date Filled		Days' Supply	

VALID 11-digit NDC #	Quantity
Total Quantity	
Total Charge	

When to use this form

Use this form to submit claims for medications dispensed at a nonparticipating pharmacy due to an emergency. You must submit claims within 1 year of date of purchase.

* California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
* Pennsylvania: 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.

Visit us online anytime at **www.bcbsnc.com**.